Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:50 AM 2010 Harry Schmuff, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore oseda 40SPIta Mare Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Hours Days 1 XM 2 □ F Yrs Maryland 2/27/1921 89 **Director** 212-12-6456 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County oriant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it is Medical Examinational to mainlist at 1 ☐ Yes 2 X No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with S. A. 21221 Funeral 2207 Wicomico Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No
If Yes, Give 1942
Year or Dates: 1945 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔯 No Specify. Specify. q 3 Widowed 4 Divorced White Baltimore, Maryland 21215-003 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 <u>Letter Carrier</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be f and Mental 2 н. Schmuff, Sr. Ada Dasch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Wife) Pages 1 and 2 s ment of Health ar permit. Pages 1 and 2 to Department of Health at Important: If Item 27 Is any Injury or other trau 2207 Wicomico Road Essex, Maryland 21221 Charlotte Elizabeth Schmuff Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. Middle River, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last r as a consequence of): Examine phagio The law requires that the death certificate be executed sician and burial-trans to (or as a consequence of): attending physician for use as the buria P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 XNo Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nours after death neral Director: / filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000 Frank 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 06 Registrar

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Physic edical Exam		DENT					2. Date of Dear Month April 3, 20	Day Year	3. Time of Death 1205 hrs
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	3		STUDENT				EDUCATI	ON
filed w Hygie d othe		17. Father's Name (First, Middle, Last)					Name (First, Middle, M	faiden Surname)	
212 uld be Menta marke	To Be	BRIAN SIMON 19a. Informant's Name/Relationship (Type, Print)	- 1	19b. Mailing Addr	ess (Stre	NASI et and Numb	CIN per or Rural Route Num		LRAHIM e. Zin Code)
MD 12 sho th and 127 is		BRIAN SIMON/FATHER	1				Γ, BALTIMOR		
nore, ages I and of Heal nt: If item		20a. Method of Disposition 1	20b. Plac	e of Disposition (Name of ce	metery,	Date	20c. Location - City o	r Town, State
time t. Page tment rtant:		4 Donation 5 Other Specify:	CEN	METERY			4/4/2010	BALTIMORE	
Balt permit. Departs Import injury		21. Signature of Funeral Service Licensee				s of Facility	SOL ELVINS		
Physician		23a. Part I. Enter the disease, or complications that caused	the death. Do	not enter the mo	de of dying,	such as car	OWN ROAD, Prodiac or respiratory arre	st, shock, or heart	Approximate Interval
/Medical examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Pentobarb	ital in	ntoxicat	ion				Between Onset and Death
		or condition resulting in death) Due to (or as a conse	equence of):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	equence of):						
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Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physici page 2 should be detached for use as the buri	an/Medical	IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? 23c. If yes, outcom 1 Live birth	ne of pregnanc	cy 2 Fetal dea	ith 3	Ectopic p	pregnancy	23d. Date of deliver Month	y Day Year
OX 6 eath ce attend for use	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	time of death	5 Other (S	pecify)			1	-
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical	Check only one) 2 Medical Examiner; On the basis of exam and manner stated.							
FSFS	ž	29b. Signature and title of certifier		7	29c. Licens			29d. Date signed (Mo.	nth, Day, Year)
•		N_ML_m			O.C.I	И.Е.		April 4, 2010	
		 Name and address of person who completed cause of de Donna M. Vincenti, MD Assistant Medica 			n Street	Baltimore	e. MD 21201		

State 31. Date filed (Month, Day, Year)
Registrar APR 0 6 2010

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** APRIL 3. 2010 AM SCHNEIDER 6:15 RHONA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BRIGHTWOOD CENTER BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 10/29/1927 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 Ϊ 82 MD **Director** 214-20-9293 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he maritand any Injury or other traumatic event, the Medical Examiner must he maritand and Injury or other traumatic event, the Medical Examiner must he maritand and Injury or other traumatic event, the Medical Examiner must he maritand and Injury or other traumatic event, the Medical Examiner must he maritand and Injury or other traumatic events. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 4537 MARYKNOLL ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT **BESS** SAMUELSON ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAIN DROP CIRCLE, REISTERSTOWN, MD 21136 MICHAEL SCHNEIDER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY | 4/4/2010 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Juneral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Brain Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner the section of the se Sequentially list conditions, if any, bearing to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CONCAN ENNA Due to (or as a consequence of): physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perform 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 27. Manper of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

Division or Attending within 2

death certificate be executed

The law requires that the

Physician:

P.O. Box 68760

or Vital Records,

Baltimore, Maryland 21215-0036

State

J- MRPARA

31. Date filed (Monta

Registrar

DHMH 17 Rev 1/2001

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Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DVIVB

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29d. Date signed (Month, Day, Year) 04-03-10

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 201 /Medical 4c. County of Death la. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 05/12/1978 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Philippines 31 194-76-0979 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f sl notified 1 Yes 2 No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip-Code 10g, Citizen of What Country? 23a or 2 must be 11416 Connecticut Avenue 20895 United States Funeral 14. Race - American Indian, Black, White, etc. or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2XXNo
If Yes, Give Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite Examiner 1 ☐ Never Married 2 XMarried Baltimore, Maryland 21215-0036 Specify: Philippine 1 ☐ Yes 2 📈 No Specify ۾ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Parts Manager Honda 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sancho D. Talag Teresita Garcia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jocelyn P. Talag - Wife 11416 Connecticut Avenue Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place)
SS. Peter & Paul
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Department of I 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/30/2010 Springfield, PA 19064 Injury (4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility David J. Weber Funeral Homes PA any 401 S. Chester Street Baltimore, Maryland 21231 Part | Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Repatoullular /Medical Due to (r as a consequence of) Examiner Henenhs Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and d for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ filled in by the funeral director, page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has Yes 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident (Month, Day Year) Injury 5 Pending investigation 1 Yes 2 No М 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 29a. Certifier 1 Xcertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) completely and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Geoffre 31. Date filed (Month, Dey, Year) State park Registrar APR 06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 📗 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Barbara April 03 Maxine Taylor M 5:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Smith Life Center Mantagrery Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Days Hours Min 11/11/1937 242-56-2890 North Carolina 72. Director Usual Residence of Decedent 28a-f shov 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director items 23a or 28a-f s ner must be notified Rockville MD Mantagrery 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 7822 Oracle Place 1100 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō ò 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. "natural", Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Social Worker D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental F item 27 is marked of other traumatic ever . Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o ပ Uhknown Lena Lytch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl D. Taylor - Daughter 7822 Oracle Place; Rockville, Md 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 04/07/2010 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee/ 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part 1 Enter the disease, or comp ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate shock, or heart failure. List only of immediate Cause (Final Interval Between Onset and Death Physician/ Due to (or as a consequence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death signed by the a Unknown To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes No 3 Probably 4 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital nours after death.

neral Director: After this of a filled in by the funeral dire 2 No မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manuer of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury 1 Yes 2 No M Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29c. License number 29d. Date signed (Month. Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 20852 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death [□]201<u>0</u> Physician/ April 2, Ethel Thompson 14:25 Lea Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George Prince George Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🖵 F Hours (Month, Day, Yea 89 577 20 0809 Director 1920 rginia Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 V No MD Prince George Capitol Heights 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 530 Capitol Heights Blvd 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 XXVo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify. Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Book Keeper Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Coppage Hattie Heflin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilmer Brighwell (SON) 23243 Willow Creek Way, California, MD 20619 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 4/12/2010 Suitland, Maryland Lee Funeral Home, Inc 6633 01d Responsible Ferry Road. Clinton, MD 20735 eral Ser/ce Licensee m0139 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Carchiosenic disease or condition Medical resulting in death) Examiner Cardiomyopath Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Track 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 🔼 No Other: ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a
To the Funeral D Hospital 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 04/02/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , cheverly , Maryland, Prince George Jagdee/ Sing IMD, 300/ Hospital DOING 31. Date filed (Month, Day, Year) State Registrar APR 0 6 201

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 1Hom As APRIL 6.55 A M **Physician** OBERI 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Augsburg Lutheran Home Gwynn Oak Baltimore 8. Date of Birth (Month, Day, Year) July 24, 1927 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 X M 2 □ F Maryland 216-20-5224 82 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Evaminer rust be notified at 1 ☐ Yes 2 ☐ No Director Ellicott City Marvland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō **USA** 21042 2194 Mount Hebron Court items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 194
If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 n and Mental Hygiene. 1 ☐ Yes 2 ☒ No Specify: White 1946 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Union Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Gannon John Thomas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 is any injury or other traughter. Jessie Thomas, Wife 2194 Mount Hebron Court Ellicott City, MD 21042 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 04/05/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WITH LIVER METARITAIS Immediate Cause (Final ANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, physician the burial Physician/Medical attending use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? for Dav 5 ☐ Other (specify) ed by the a 9 I Unknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a. Was an certificate has autopsy page 2 1 ☐ Yes 2 No or Attending Physician: funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Hospital 29a, Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 28595 shew 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15+11 SUITE 203 >/か1774 32. Regis State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Tartaglione Andrew J. **Physician** аМ 2010 8:15 April 2 /Medical County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Friends Nursing & Rehab Center Montgomery Sandy Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 1X M 2 ☐ F 90 116-07-3077 July 24, 1919 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Examiner must be notified at Brookeville 1 □Yes 2¥ No MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō death with **USA** 20833 19109 Georgia Avenue items 23a 12. Was Decedent Ever in U.S. Armed Forces? US Navy If Yes, Give Year or Dates.WW II 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No ò Specify: White þ 3 ₩ Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. unt: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Food Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental P Anna Petrosini Giovanni Tartaglione 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13308 Magellan Ave., Rockville, MD 20853 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trau Kathleen A. Franke / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4/5/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota Marshall Marshall PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Artery Daeane **Physician** Loronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

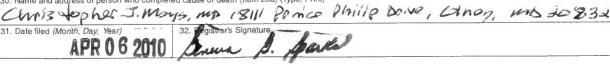
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. the q Unknown cate has been signed by page 2 should be detact 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 Failure 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabertes 24a. Was an certificate has autopsy performed 1 ☐Yes 2 ☐ No 2 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ₹No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

12 State Registrar

31. Date filed (Month, Day, Year)

(Check only

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

29c. License number

D34773

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert Mason Underwood, Jr. :00 PM M Anri 1 Medical 4c. County of Death Prince George's 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Southern Maryland Hopital Clinton Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept 26. Mary I and 1 X M 2 🗆 F **Director** 213 98 3839 30 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes XX No Maryland Prince George Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6913 Briarcliff 20735 United States items within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or Nollf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc ō 1 X Never Married 2 Married Completed by 1 Yes If Yes, Gi 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced Specify: "natural", Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Disabled N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Mason Underwood, Sr. Deborah J. Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah J. Underwood, (Mother) 9116 Simpson Lane, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apri 18.2010 ■ Burial 2 □ Cremation 3 □ Removal from State Clinton, Maryland 4 Donation 5 Other (Specify) Resurrection Cemeterv Signature Funeral Service 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d M0/391 Alexandria Ferry Road, Clinton, Maryland Pard. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of and burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 this certificate 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending work' 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 04/05/2010 30. Name and address operson who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day,)
APR 0 6 32. Registrar State Registrar

DHMH 17 Rev 7/2009

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		Examin		4a. Eacility Name (if not Institution, give	•			r Location of Death		1c, County of Deat	_ /
	***	Funeral	/		ex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	Last and	Date of Birth		thplace (State or Foreign
		Director	1 3	213-12-4426 Usual Residence of Decedent	1 □ M 2 S F	Yrs.	World S Days	110013	Date of Birth (Month, Dat Gear	8 501	MD
	Maryland	Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show yinjury or other traumatic event, the Medical Examiner must be notified at once.	Director	10a. State 10b. County		10c. City, Town or Lo Buttin	more				10d. Inside City Limits 1
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ď	after deat	or iten miner r	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ 🔻	9	If Yes, specify Cuba	lispanic Origin? (Specify an, Mexican, Puerto Ric	Yes or No- an, etc.)	14. Race - Ame Black, White	
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	1 and	of Healt item 2 other		20a. Method of Disposition	gers Nie	20b. Place of Disp		Date Date	eltinov	· •	Town, State
Stingra	permit. Page	tment tant: If ijury or		1 → Burial 2 □ Cremation 3 I 4 □ Donation 5 □ Other (Spec	cify)	Hout	us Mema	srial 48-	10 +	rbutus	s, mo
<u>a</u>	permi	Depar Impor any in once.		21. Signature of Funeral Service Lice	F. Freez	ع ا	2. The and Addre	ss of Facility Gree	or fune	1279)	grices
0				23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused to one cause on each line.			g, such as cardiac or re	espiratory arrest,		Approximate Interval Between
100		ysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	CA CLE consequence of):	Les				Onset and Death
4	E)	caminer		Sequentially list conditions,	b	ailer	e to	thriv	و		reverelno
- 2	ted	insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Dumito (or as bi	consecuence off					
2	e executed	ian and urial-tra	al Ex	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
1 1 6	certificate be	physic s the bi	ledic		d						
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ر الم	cian: T	ertifical ector, p	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Check or		NO TES	5 242 190
ر کرک کرک	Physi	ar this c eral dire	e: To	1 ☐ Yes 2 ☐ No 27. Manner eath	1 Inpatier		of 28c. Injur	4 Wursing Home y at 28c	5 Residence		cify)
3	Attending	eath. or: Afte the fun	Certificate:	1 atural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	he			(? Yes 2 □ No			
ي و	To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached.		4 Homicide determined	building, etc.				Location (Street a City or Town, Sta	te)	
	e Hosp	n 24 hol l e Fune bleted fi	Medical	(Check 2 Medical Exar	ysician: To the best of m niner: On the basis of exa rse_Practioner: To the be	amination and/or inve	stigation, in my opinio	on, death occurred at the	time, date and place	ce, and due to the	cause(s) and manner stated.
4	Toth	withi To th		29b. Signature and title of certifier	~~v.		29c. Licens	e number	29d. D	Date signed (Month	h, Day, Year)
	6	J		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print) Frede	36942 wide Rd.	Rallin	ne ri	0 2/228
		Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	a Signature	1		4		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25 per me,g902,04/05/.2010dhb Certificate of Death Reg. No. Amend Item - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Month Day Physician/ Mary White 00:50 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Med Maryland of Baltimore Maryland niversit | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June | 9,1940 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Maryland 216-36-6095 **Director** Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Suxsex 1 Tes 2 No DE. Ocean View 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33426 Oak St. 19970 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No White Specify. Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me University Of Maryland Elementary/Seconday (0-12) 12TH College (1-4 or 5+) Manager Baltimore County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roland Rancliff Cole Dorothy Katherine Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson C. White,Sr./ Husband P.O.BOX 1544 Ocean View, DE. 19970 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 3/25/ 2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility AMBROSE FUNERAL HOME INC. atricia Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory rrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hemorrhag Intraventricular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of CERTIFICATION APPROVED BY MEDICAL EXAMINER that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day 9 Unknown 本ススペナエ Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year) APR 05 2010

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32 Registrar's Signatur

ereur

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Items 23a, FLI, Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 855 2010 Janun Medical 4a. Fadility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Bay 1 💢 M 2 🗆 F Months Days Hours **Director** Usual Residence of Deceden 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2 No mor 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be Funeral 23a r items should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired), Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementajý/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) ပ Lsister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 282 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dart cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 5 Other (Specify) 21. Sanature Fuveral Service Licer 22 Name and Address of Facility Balto Ma. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line. **Complications** ing, such as cardiac or respiratory arrest.
End Stage Liver Disease the mode of dyi Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ue to (or as a cons the burial-transit that the death certificate be executed and EXMINE that initiated events resulting in death) Last as a consequence of) CATION APPROVED BY NEW physician Physician/Medical Box 68760 for use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No detached a 🗌 Unknown 9 Unknown P.O. 1 ģ ins certificate has been signed l' director, page 2 should be det. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by law requires Vital Records, 1 🗌 Yes 2 **N**o 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? To the Hospital or Attending Physician; The 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this o filled in by the funeral 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending ivision 1 Yes 2 🗀 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, 2010 ted cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) APR 0 6 201

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Montal Hygiene 25,27,28a-f per me,8902,04/05/2010dhb Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 1340M Stel **Physician** 11Stleman 010 anuary a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) 4/14/1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 82 vrs If Under 1 Year If Under 24 Hrs. 5. Social Security Number Min **Funeral** Months Days Hours 1 M 2X F 220-22-9393 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD N/A Baltimore 1X Yes 2 ☐ No Director ir than "natural", or Items 23a or 28a-f s the Medical Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21218 USA 614 Montpelier Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: þ white 3€Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Manufacturing Elementary/Secondary (0-12) College (1-4 or 5+) other than Factory Worker 8 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk Sampson Unk and Mental is marked ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 446 5th Avenue, Brooklyn Park MD Jesse J. Whistleman/ Son Department of Health Important: If item 27 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery 1/11/10 Baltimore MD ō injury o 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License ictor P. Doda, Jr 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc
1501 East Fort Avenue, Baltimore MD any 21230 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** nematoma should disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the death certificate be executed attending physician and Due to (or as a consequence of): CERT Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signed ş Division of Vital Records, page 2 should be 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 Yes 2 🗌 No 2 X-No certificate 26. Place of Death (Check only one) 25. Was case referred to medical completely filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 1 Anpatient 2 ER/Outpatient 3 DOA မှ 28b. Time of **p** • **m** 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident or Attending 5 Pending investigation 01/05/2010 **Unknown**_M Subject fell 1 🗌 Yes 2X No death. Director: Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) **Home** 28f. Location (Street and Number or Rural Route Number, City or Town, State) 614 Montpelier Street, Baltimore, MD determined 4 Homicide the Hospital within 24 hours the Funeral 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only

State Registrar

31. Date filed (Month, Day, Year,

Gibbs

29b. Signature and title of certifier

ane)

APR 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

and manner stated.

MD

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Month Zabel 2010 3:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Charlestown Retirement Catonsville Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Virginia 1 M 2 X F Months July 29, Year) Director 228-38-4483 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 715 Maiden Choice Lane HV-215 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 K Divorced Year or Dates. White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Administrator County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Archibald W. Thomas Eva Marguerite Cully 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Highlands Lane Stephen Wicke Malvern, Pennsylvania 19355 (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State Atlantic Crematory 4-6-2010 4 Donation 5 Other (Specify) Glen Burnie, Maryland Signature of Juneral Service License 22. Name and Address of Facility
Witzke Funeral Homes,
5555 Twin Knolls Road Inc. 23a. Park 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Meta static Lung Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 Oo Be 26. Place of Death (Check only one) Hospital: Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation 24 hours after deat Funeral Director; completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) з 🗌 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V Choice Lane. 31. Date filed (Month, Day, Year) State 32. gistrar's Signature APR 06 Registrar

			State Registrar			Cei	rtificat	e of l	Death			Reg. N	0.2010	10515
	884	-1	1. Decedent's Name (First, Middle, Last,)					_	2.	Date of De Month_		ay Year	3. Time of Death
	Physicia /Medic		Wade Lawrence V	Villiams						A	pri1	1,	ay 2010 Year	16:04 M
E. K	Examin	- 1	4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of D	Death		4	c. County of Death	1
A.			Fort Washington	n Hospital	_				Washir				Prince Ge	
	Funeral		Social Security Number 6. Se		e (In yrs. la	as <i>t birthday</i>)	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. Min.	Date of Bir (Month, Da	th ay, Yea	9. Birth	place (State or Foreign intry)
	Director		578 34 3468	M 2□F	81	Yrs.	Monthle	Dujo				-	1929 Mar	
	pc ,		Usual Residence of Decedent		100 City	, Town or Lo	action							10d. Inside City Limits
	arylar show d at	<u>_</u>	10a. State 10b. County		Toc. Gity									,
	Ba-f s	용	Maryland Prince Ge	eorge		Acco	keek							1 □ Yes 2 □ No
	or 2	Director	10e. Street and Number				10f. Zip	Code				10g. C	citizen of What Cou	intry?
	23a ust k		408 Biddle Road					206					nited Sta	
	r de ser m	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		3. 13.	Was Dece If Yes, spe	dent of H cify Cuba	ispanic Origir an, Mexican, I	n? (Specify Puerto Ric	/ Yes or No an, etc.))-	14. Race - Amer Black, White	
36	s afte , or i amln	by Fi	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 📉 If Yes, Give	No		1 □ Yes	2 X No	Specify:				Specify: Whi	te
215-0036	72 hours after death with the Marylan "natural" or items 23a or 28a-f show dical Examiner must be notified at	g D		Year or Dates:		16a. Dece	dont'o I lou	al Occup	ntion			16h	Kind of Business/I	- 1979
5	"nat	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	Î	(Give	kind of wo DO NOT u	rk done i	during most o	f working	1.0	100.	Kind of business/i	ndustry
12	withir	ם	Elementary/Secondary (0-12)	College (1-4or 5	5+)				•			Aı	utomotive	7
121	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ther than must be notified at ent, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)				y Tec	nnic		s Name (F	irst, Middle	1	en Surname)	
anc	ould be f Mental I tarked of tatic eve	Be	_ `	lliams					_	adie	Stam			
Maryland	ges 1 and 2 should be filed within 72 hc of health and Mental Hygiene. If item 27 is marked other than "natuu or other traumatic event, the Medical	ည	19a. Informant's Name/Relationship (7)			19b. Mailii	na Address	(Street					or Town, State, Z	in Code)
Ma	alth and 27 is ma		Mary Williams (Wi	•			•	,	Road,					,
Ġ,	1 and 2 Health tem 27 i		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Na	me of	i	Date)	20c.	Location - City or	Fown, State
Baltimore,	Pages nent of P int: If ite		1 ABurial 2 □ Cremation 3 □ F			emetery, cre	-		Apr		, 201	D til	.1.JE N	Sa
Ē	permit. Page Department o Important: If any injury or once.	1	4 ☐ Donation 5 ☐ Other (Specify, 21. Signature Funeral Service Licens		1r				Garden				aldorf, M	
Ba	permit. Page Department of Important: If any injury or once,	4 1	The state of the s	a (m	م سے در پر ہ	2 A	1e y an	dria	Ferry	Lee .	runera	a⊥ i Mn	Home,Inc 20735	6633 OTG
		-	23a Part Enter the disease or comp	dications that caused	the death								20733	Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	/					3,		,			Interval Between Onset and Death
25	Physician /Medical		disease or condition resulting in death)			10 WARY	AL	Kest						
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52		<u>-</u>	Sequentially list conditions,	b. LOROM Due to (or as		Mence of).	Discon	_						
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· Emply		,								
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68760,	requires that the death certificate be executed een signed by the attending physician and rould be detached for use as the burial-transit			_										
687	ficate phy s the	Medical		u										
×	certi nding se a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf <u>pr</u> egna	ncy	_						23d. Date of deli	very
Bo	leath cer attendin I for use	Cial	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a			⊒Ectopic p ⊒ Other <i>(s</i> j		/				Month	Day Year
P.O.	uires that the de signed by the a Id be detached f	Physician	9 ☐ Unknown	9□Unknown										
	that ned b		Part II. Other significant conditions co	ontributing to death b	ut not resu	ulting in the u	nderlying (cause giv	en in Part I.		23e. Did	tobacc	o use contribute to	the cause of death?
rds	quires n sign	d by									1 🗆	Yes	2 No 3 Pr	obably 4 [4Un known
OS	S 0 S	Completed									24a. Was	s an	24b. Were au	topsy findings available
Re	The law ite has b bage 2 sl	삞								_		ormed	death?	completion of cause of
Vital Records,	ifficat	Ö	25. Was case referred to medical						26. Place o	of Death //	1□ Yes	2 🗹 I	No 1 □Yes	2□ No
>	Physician: r this certific ral director,	0	examiner?	Hospital: 1/ Inpati	ent 2□	ER/Outpatie	nt 3∏ D	OA Oth	or:				6 ☐Other (Spec	cify)
Division or	J Phy er this eral d	- To	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time o		28c. Injui Wor					jury occurred	Silyy
on	th. : Afte	tior	1 ✓ Matural 5 ☐ Pending 2 ☐ Accident investigation		y Year)	Injury	M		κ? Yes 2 ∐ No	0				
/isi	l or Attend after death Director; / I in by the f	fica	3 Suicide 6 Could not be	Zoe. Flace of III	ury - At ho	me, farm, st	reet, factor	ry, office		28f	. Location	(Street	and Number or Ru	ıral Route Number,
D	after after Dire	Certification:	4 Homicide determined	building, e	с. (Бресіт)	//					City or To	own, St	are)	
	spita nours neral	2	29a. Certifier 1 Certifying Phy	ysician: To the best	of my kno	wledge, dea	th occurred	d at the ti	me, date and	place, an	d due to the	e cause	e(s) and manner as	stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2☐ Medical Examone)	ilner: On the basis of and manner st		tion and/or ii	rvestigatio	n, in my	opinion, death	n occurred	at the time	e, date a	and place, and due	e to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	-			29	c. Licens	se number			29d. [Date signed (Mont	h, Day, Year)
			Ma oc Luis				j	230	10 (1	00			04/02/	2010
	1		30. Name and address of person who d	completed cause of	death (Item	23a) (Type	Print)	~					1 -1	
			Alfred Burris M					E	Washin	oton	DC 1	2003	32	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR U 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	te of Maryland		artment of F <i>tificate of L</i>			giene Reg. No.	10	10516
Physic	ian/	1. Decedent's Name (First, Middle, Last) Carol A. Whita	ker	•			2. Date of Dea		Year	3. Time of Death
Med Exam		4a. Facility Name (if not institution, give street and				Location of Death		4c. County	of Death	10:35¢ M
Funera	al	12 Terrace Road 5. Social Security Number 217-38-9806 1 □ M 2 □	7. Age (In yrs. las	t birthday)	If Under 1 Year	SSEX If Under 24 Hrs. Hours Min.	8. Date of Birt	h		place (State or Foreign
Directo	r	217-38-9806 1 ☐ M 2 ☐ Usual Residence of Decedent	^{XF} 69	Yrs.	Months Days	Hours Willi.	0000	7 /earl 9 4 0	Coun	PA
aryland a-f shov	ector	10a. State 10b. County MD Baltimore		Town or Loc	sex				1	0d. Inside City Limits 1 ☐ Yes 2X No
th the M 3a or 28 t be noti	Funeral Director	10e. Street and Number 12 Terrace Road	1		10f. Zip Code	1221	T	10g. Citizen of V	Vhat Coun	ntry?
Iryland 21215-0036 ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at		11 Marital Status 12. Was	Decedent Ever in U.S. ed Forces?	13. V	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Rac	e - Americ k, White, e	
ns after arral", or	ed by	K If Ye	ed Forces? Yes 2 No s, Give or Dates,		☐ Yes 2 🛣 No			Specify:		ite
215-C	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	(Give H	O NOT use retired)	ation during most of work	king	16b. Kind of Bu		dustry
d 212 ed within Hygiene other the ent, the	Be Co	Elementary/Seconday (0-12) Colle 1 2 th 17. Father's Name (First, Middle, Last)	sge (1-4 0/ 5+)	Home	maker	18. Mother's Nan	ne (First Middle	own h		
Marylan (should be file and Mental or is marked contamental or is marked contamental or is marked contaments).		John Doran					hy Klo			
d 2 should 12 should 12 should 12 should 12 should 12 should 12 should 15 sh		19a. Informant's Name/Relationship (Type, Print) Tim Whitaker /so:		19b. Mailin	g Address (S <i>treet a</i> Terrace	and Number or Rui Road B	al Route Number altimo:	r, City or Town, S re MD 2	tate, Zip 0 2122	Code) 1
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam		20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State Cer	metery, crem	sition (Name of natory or other place Cremat	orvi ///	Date 6 10	20c. Location - Balti	•	
Baltii permit. P Departm Importal any injur		21. Sign ware of Funeral Service Licensee	2	22	. Name and Addres	ss of Facility 3	00 Mace			timore MD
		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	on each line.		r the mode of dyin	g, such as cardiac	or respiratory arr	est,	ESS	Approximate Interval Between
Physician Medica	a!	Immediate Cause (Final disease or condition resulting in death)	ue to (or as a conseque	o Ca	rdial	ufaret	<u></u>		-	Onset and Death
Examine		Sequentially list conditions, b. ——	Lux	-	ance	v				
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events c.								
760 cate be executed physician and the burial-transit	edical E	resulting in death) Last Du	ue to (or as a conseque	nce of):						
68760 ertificate b Iding physics se as the b		IF FEMALE: 23c. If ye	s, outcome of pregnance	cv				024 Da	o of dollar	
Division of Vital Records, P.O. Box 68760 tal or Attending Physician: The law requires that the death certificate be executed rs after death. In birector. After this certificate has been signed by the attending physician and ed in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	Live Birth 2 D Fetal of Pregnant at time of de Unknown	death 3 🗆	Ectopic pregnand Other (specify)			Mo	e of deliventh	Day Year
, P.O.	₽ P	Part II. Other significant conditions contributing			nderlying cause giv	ven in Part I.				ne cause of death?
ords w require s been s s been s	Completed	Hisperiens Disbetes	melletu	·			24a. Was a	an 24b. \	Vere autor	osy findings available
Vital Reco sician: The law i certificate has b lirector, page 2 s		(05.W)					1 Tes	rmed?	leath?	mpletion of cause of
Vita ysiciar is certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ E	R/Outpatien	Oth	ace of Death (Checer: 4 Nursing H	ome 5 Resid	lence 6 🗆 Othe	er (Specify)
on of Vital Inding Physician: Tath.: After this certification of the function		27. Mann of Death 28a. 1 Natural 5 Pending 2 Accident Investigation	Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury work M 1 🗆	y at		ow injury occurre		
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Certificate:	3 Suicide 6 Could not be	Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural	Route Number,
Hospita 24 hours Funeral eted filler	Medical	29a. Certiffer 1 Certifying Physician: To (Check 2 Medical Examiner: On the	ne basis of examination a	and/or invest	igation, in my opinio	on, death occurred a	at the time, date a	nd place, and due	to the cau	use(s) and manner stated.
To the within To the compl	Σ	only one) 3 Certifying Nurse Practic	oner: To the best of my R	knowledge, c	29c. License	e time, date and pla	ce, and due to the	29d. Date signed	(Month, L	Day, Year)
		only one) 3 \(\to \text{Certifying Nurse Practice} \) 29b. Signature and title of certifier Romand attention of person who completed Romand ATT MAGE 31. Date filed (Month, Day, Year) APR 0 6 2010	cause of death (Item 2	23a) (Type, P	rint)	28091	<i>c</i> ==	4/5/1	· .	
	ate	KONAD ATTAWASA 31. Date filed (Month, Day, Year)	9/14 32. Registrar's Signatur	phila	delphi	alld.	sul !	08 (3	alt.	Md.21237
Regis		APR 0 6 2010 4	was A.	DOLL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2010 1:50 P Thomas Albert Wisner April /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Hospice Calvert Prince Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

June 29, 1 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Hours Days 577-42-2110 79 1930 District of Columbia Director Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventher must be notified at 1 ☐ Yes 2 X No Director Calvert MD Lusby 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number filed within 72 hours after death with 20657 USA 1726 Sollers Wharf Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1950–54 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Environmental Elementary/Secondary (0-12) College (1-4or 5+) Educator Education 12 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Isetta Baber William Frank Wisner Katherine ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) l and 2 s Health a tem 27 is Box 314, Anchor Point, Alaska Department of Health Important: If item 27 any injury or other troopie. Mark Wisner, son 20a. Method of Disposition
1 □ Burial 2 ★Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 nent of F Metro Crematory, Inc. 04/03/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road 21228 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician C CUNC -una disease or condition resulting in death) /Medical Due to (or as a consequence of) Lyecus Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transi Due to (or as a consequence of): physician a the burial P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospice Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of Injury ne Hospital or Attending Pl n 24 hours after death. Ie Funeral Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

6 V

State

DHMH 17 Rev 1/2001

Registrar

10 238 Merrimac C+
32. Rygistrar's Signature Kaymon A Noble 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NID

PRINCE Frederick, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3.45P 2. Date of Death Physician/ AVZIC 20,00 Wilhelm Ruth Cornelia Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALAMORE AMME WASHINGTON MEDICAL CENTER 8. Date of Birth (Month, Day, Year) 06/27/1923 Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕅 F Country)
Maryl Director 216-16-2592 86 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral 6701 White Water Court #102 21060 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter or. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify: 3 X Widowed 4 □ Divorced White Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Service Service Associate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gilpin Dona Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 Health tem 27 6701 White Water Ct. #102 Ms. Susan Wilhelm / Daughter Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Important: If it any injury or o 4 Donation 5 Other (Specify) Atlantic Crematory 04/04/2010 | Glen Burnie, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21061 Glen Burnie, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner ME Sequentially list conditions, Examine il any, leading to influentiate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No jo Day 9 Unknown cate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate ! Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural work? 5 Pending 2 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature e of death (Item 23a) (Type, Print Name and address of person who com Glen Burnie www.hal

State Registrar

Milhem

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per Fh G902 4/16/10 TT

Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) **Physician** 2010 George /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Bin 04/23/1927 9. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** MD 82 216-28-3552 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a. State 1 ¥ Yes 2 □ No Director BALTIMORE MD 10g, Citizen of What Country? 10e. Street and Number 10f. Zip-Code Funeral USA 17 CARDINAL LN 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11. Marital Status Black White etc 1 Never Married 2X Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give þ 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH FARMER FARM 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CORA PEYTON FRANK GEORGE WILLIAMS ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17 CARDINAL LN., BALTIMORE, MD 21221 JANET MAY WILLIAMS/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 04/02/2010 | HANOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) ARDENT 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licensee 2007-09 EASTERN AVE., BALTIMORE, MD es 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Show **Physician** /Medical Examiner ardiogenic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as Honsequence of): or Attending Physician: The law requires that the denth certificate be executed physician and is the burial-tran: that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Dav in the past 12 months? 5 Other (specify) 1 Yes 2 9 Unknown 2 No detached P.O. 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 6 Other (Specify) ပ္ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 🗶 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 27th 2010 265-000 30. Name no address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 JORDAN SAX APR 0 6 32. R gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Darke

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

					State of	r Marylan		ertificate of			Jiene Reg. No.2	10	10520
	Physici	an	1. Decedent's Nam	e (First, Middle, La					-	2. Date of Dea Month	th Day	Year	3. Time of Death
	/Media	al	4a Facility Name (/	If not institution si		arry E	Walla		4b. City, Town, or L		far 24, 201		4:45p
	Examir	er	4a Facility Name (/		e CareCha		۵			тоге	,o. county	N/	A
	Funeral		5. Social Security N	lumber 6. S	Sex	7. Age (In yrs.	last birthda	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	, Year)	9. Birthpi Coun	lace (State or Foreign try)
	Director		220-80-	8/62	IQ M 2□ F	49	Yrs.			Feb 5			laryland
	yland how		10a. State	10b. County		10c. Cit	ty, Town or	Location				10	Od. Inside City Limits
	Ba-f el	Director	Maryland		VA.				altimore				1 X Yes 2 No
	with th	Dire	10e. Street and Nur	mber in Street - #1:	510			10f. Zip Code	21217		10g. Citizen of W	hat Coun U.S.A	-
	daath	Funeral	11. Marital Status	III Oticet - # 1	,	dent Ever in U	,S. 13	. Was Decedent of I		pecify Yes or No-	14. Race	- Americ	an Indian,
21215-0020	be filed within 72 hours after death with the Meryland teal Hygiana. d other than "naturel", or items 23s or 28s-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Marri 3 ☐ Widowed	ied 2 Married 4 Divorced	1 Yes If Yes, Giv Year or Da	2 1 No		1 Yes 2 No		o Alcan, etc.)	Specify		Black
5-6	natu natu	letec	(Spec	15. Decedent's E lify only highest gra	ducation ade co <i>mpleted)</i>		16a. Dec	edent's Usual Occup re kind of work done DO NOT use retire	oation during most of work	king	16b. Kind of Bu	siness/Inc	lustry
212	lana. then	Completed	Elementary/Seco	ndary (0-12)	College (1	-4or 5+)	,,,,		pecialist		Hea	lthcare	Center
	al Hyg lother vent,	BeC	17. Father's Name	(First, Middle, Last)		-		18. Mother's Nam				
Maryland	d 2 should be filed within the and Mantal Hygiana. 7 Is marked other than traumatic event, the Mantal traumatic event.	To I			/allace Sr.		1				abeth Davis		0.11
Ma			19a. Informant's Na Sharon Jol		Type, Print)			iling Address (Street 2417 Huron St				State, Zip	Code)
Je,	of Haalth of Health of Item 27 is		20a. Method of Disp	position			Place of Dis	position (Name of ematory or other pla		Date	20c. Location -	City or To	wn, State
Baltimore,	Pag nent ant: i			☐ Cremation 3 ☐ 5 ☐ Other (Specil				Cemetery & f		04/05/10	Broo	klyn Pa	ark, Md.
Ball	permit. Page Dapartment of Important: if any injury or pnce.		21. Signature of Fu	neral Service Lice	Pater	0		22. Na <i>m</i> e and Addre Estep E 1300 E	ess of Facility Brothers Fune utaw Place Ba	ral Service, altimore, Mo	P. A. 121217		
			23a. Part1. Enter the shock, or hea	ne disease, or com n failure. List only	plications that cone cause on e	aused the deat ach line.	h. Do not e	nter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	1	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	01	gron	arus	Duter	1	Dise	ase	1	
	Examiner		disease or condition resulting in death)	n	a		«/	equence of):	/				
1	ed sit	niner			b							i	
Mg.	Attending Physicien: The law requires thet the deeth certificete be axecuted in deeth. sctor: After this cartificete hes baan signed by the ettanding physician and by the funerel director, page 2 should be deteched for use as the burial-trensit	i Examiner	Sequentially list confidence in any, leading to impresse. Enter Under Cause (Disease or	nditions, nmediate orlying		Due to (c	or as a cons	equence of):					
68760,	ificeta b g physic as tha bi	edicai	that initiated events resulting in death) I		C	Due to (o	r as a cons	equence of):					
Вох	ettanding for usa	Physician/M			d							i	
0.	tha ett	ysici	Part II. Other signif	icant conditions	ontributing to de	ath but not res	ulting in the	underlying cause gi	ven in Part I.	23b. Did t	obacco use cor		the cause of death?
₫.	thet tha de ned by tha detechad	by Ph	Higu	rud	Fru	nedef	nu	ney by	rdhom	e 10'	fes 2□ No	3 Prob	oably 4,⊠Unknown
Division of Vital Records, P.O.	tquires the an signed ould be del	ed b	TA	105)		1		/ /			an autopsy	ava	ere autopsy findings allable prior to
Seco	law raquir hes baan s e 2 should	Completed		11)-1			12					of	mpletion of cause death?
al	ysicien: The li is cartificete he diractor, page		OF Man coop refer	red to medical					00 Plans of Pass		es 2.24No	1	☐Yes 2☑No
Ž	ysician s carti diracto	To Be	25. Was case reference examiner? 1 ☐ Yes 2 ☑		Hospital: 1 ☐ II	npatient 2	ER/Outpati	ent 3 DOA Oti	26. Place of Dea her: 4 Nursing Ho	ome 5⊡Resid		er (Specifi	
ē.	ding Phys h. After this funerel di	L:no	27. Manner of Death	5 Pending		of Injury h, Day Year)	28b. Time Injury	Wo		28d. Describe I	now injury occurr	ed	
Sio	daeth daeth stor: A y the f	licati	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b	e oga Dinas	of Injury - At he	ome farm s	M 1 =	Yes 2□No	28f. Location (5	Street and Numb	er or Rura	l Route Number,
Σ	s aftar il Direct	Certification:	4 ☐ Homicide	determined	buildir	ng, etc. <i>(Specif</i>	<i>y</i>)	,		City or Tou	m, State)		
	To the Hospital or Attending within 24 hours aftar daeth. To the Funeral Director: Aft complataly fillad in by the fun	edicai	29a. Certifier (Check only one)			sis of examina		ath occurred at the ti investigation, in my o					
	with Total	Σ	29b. Signature and	title of certifier	2	51010			7543		29d. Date signed	6-71	0
	4		1	NOHU,	completed cause	e of death (Item	m 23a) (Type W - B	Print)	E ST.	BALT	IM ORE	, MO	2/223
	Sta Registr	te ar	31. Date filed (Mont	R 0 6 201	62. Re	egistrar's Signa	ature for	Med					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 29, Day 2010 Year Diane Young 7:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 48 Days 1 - M 2 XF 578-90-6364 10728/1961 Washington, DC Director Usual Residence of Decedent shov 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Montgomery 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 710 Roeder Road #101 20910 USA Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 😿 No Black, White, etc. 1 Never Married 2 Married ò If Yes, Give 1 ☐ Yes 2 K No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "naturanmatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)

2 vears Elementary/Seconday (0-12) years Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lee Ernest Young Minnie Blanks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 710 Roeder Road #101; SIlver Spring, MD 20910 Ramona Young - Sister other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or of 1XXBurial 2 Cremation 3 Removal from State Glenwood Cemetery 04/08/2010 Washington, D.C. 4 Donation 5 Other (Specify) Funeral Service Licens 21. Signature 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 20748 23a. Part 1. Enter the disease, or combinations that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or real failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary arrest Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Multiorgan failure Sequentially list puncitions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Tumor lysis syndrome attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last End stage / metastatic Breast cancer Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 X No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Renal failure 1 Yes 2 No 3 Probably 4 No Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hyperkalemia autopsy performed? Yes 2 No Septic Shock certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes _2 🔀 No 1 Impatient 2 I ER/Outpatient 3 I DOA 2 within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital Records, P.O. Physician: or Attending the Hospital

the Maryland

Baltimore, Maryland 21215-0036

5 State Registrar

Medical

29a. Certifier

з 🗆

Bhikkasi, Smitha

29b. Signature and title of certifi

1500 Forest Glen Rd, Silver Springs, Md 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0064100

29d. Date signed (Month, Day, Year)

03/29/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20a-c, Fr G902 4/21/10 TT State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1 Lay 2010 MARY ELIZABETH BUSSEY 11:14 p^M March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Cheverly Prince George's Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours Min. 1 M 2 X F Months 579-30-9646 06/16/1926 83 Washington, DC **Director** Yrs. Usual Residence of Decedent 28a-f show 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Landover 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7801 Barlowe Road 20785 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ş 1 Never Married 2 Married Yes 2 K No Yes, Give 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lih and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Government 12th Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arcelia Bassil Alpha O. Nicholson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 45263 7th Street, East, Apt 43, Lancaster, CA 93535 Gary D. Faucette- Son 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 a 04/06/2010 Cheltenham, MD State ò Chelteniam Veterans Riverdale Fark Cemetery 03/23/2010 Riverdale, Maryland Ξ 1 KBurial 2 KB tion 3 🗌 Removal from State Important; It any injury or 4 Donation 5 Other (Specify) 21. Signatura of Funeral Service License 22. Name and Address of Facility Johnson & Jenkins Funeral Home 20011 716 Kennedy Street, NW, Washington, DC 23a. Part 1. Enter the disease, or como frations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or locause of line. Immediate Cause (Final Onset and Death Physician/ FATAL CARDIAC ARRHYTHMIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as or injury Due to (or as a consequence of) Exam burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 K No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 V No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) nours after death.

neral Director. After this if illed in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0063688 March 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive, Cheverly, Maryland 20785 Griffin Davis, MD, 31. Date filed (Month, Day, Year, 32. Registr State

DHMH 17 Rev 7/2009

Registrar

MAR 2 4 2010

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Vital

of

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death RegistrarAmend#2_PerPhys_PGC3-26-10cm Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death th18_w 13 2010 3. Time of Death Physician/ MARCH 3:51 A M SMITH **DELORIS** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 12 F Months Hours Min NOV. 17 1942 FLORIDA Director 578-58-8851 67 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants I fitem 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notitied as any injury or other traumatic event, the Medical Examiner must be notitied as 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No PRINCE GEORGE'S LANHAM MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 20706 9605 BEACHWOOD AVENUE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 👿 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK If Yes Give 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COVERNMENT BUDGET_ANALYST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 VERNELL TOWNE ARTHUR SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9605 BEACHWOOD AVENUE LANHAM, MARYLAND 20706 JOHN T. BROWN/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation—5 ☐ Other (Specify) 3/25/2010 CLINTON, MARYLAND RESURRECTION CEME. nature of Fune I Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME any 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive Heart Failure Physician/ disease or condition) Medical resulting in death) e to (or as a consequence of):

Acute Renal Failure Examiner Sequentially list conditions if any leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Hypertension burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be <u>Respiratory Failure</u> Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ▼No Month Day Year Pregnant at time of death Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? After this certificate 2 No B 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral (27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? ☐ Accident ☐ Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Oertifying Nurse Practioner: nothe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated certifie 29b. Signature a 29d. Date signed (Month, Day, Year) D16273 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6130 LANDOVER ROAD CHEVERLY, MARYLAND 20785 REVATHY MURTHY M.D

State

Registrar

MAR 2 4 2010

32. Registra Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 1 5 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of De	eath	R	Reg. No.	
Physician Francis		Decedent's Name (First, Middle,Last)		Date of Dea Month	ath Day Year	3. Time of Death
Medical Exami	ner	COREY DONNELL BOYD 4a. Facility Name (if not institution, give street and number) 14b. C	ity, Town, or Location of D	March 24	, 2010 4c. County of Deat	0935 hrs
F			urel	outri	Prince George	
Funeral Director			Under 1 Year If Under 24 onths Days Hours		irth(MM/DD/YYYY) 9. Bir D-1771 Foreig Co	
ny		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location				10d. Inside City Limits
how a	L	Maryland Prince Georges Laurel				1 Yes 2 No
arylan 8a-f si	Director	10e. Street and Number 10f.	. Zip Code	1	10g. Citizen of What Cou	ntry?
and with the Maryland items 23a or 28a-f show any ast be notified at once,		13803 Briarwood Drive Apt. 1813 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	20708		-A-Z-U	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumaric event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	cedent of Hispanic Origin? becify Cuban, Mexican, Pu		White, etc.	ican Indian, Black,
rs afte ural",	þ	3 Widowed 4 Divorced If Yes, Give Yaar 1 Yes 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Us	No specify:	of work done	Specify: Bla	
72 hou	eted		working life. DO NOT use		TOD. KING OF OUSINESS/	ridusti y
036 vithin vithin on the control of	Completed	ll None			None	
15-0 filed v I Hygi ed oth		17. Father's Name (First, Middle, Last) Henman Boyd		ame (First, Middle, I L Howard	Maiden Surname)	
212 uld be Menta marke	To Be		ress (Street and Number		mber. City or Town. State	. Zip Code)
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica			riarwood Dri			
or Heal		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (crematory or other place)	ace)	Date	20c, Location - City or	
Baltimore, permit. Pages I as Department of Her Important: If ite		4 Dowation 5 Other Specify: Ft. Lincoln			Brentwood,	
Bal permit Depar Impor		Bull - Autor 500 A	and Address of Facility Allentown Ro			egy j qgs,P.A
Physician //M_di_al		23a. Part I. Enter the disease of complications that caused the death. Do not enter the mo failure. List only one cause on each line.				Approximate Interval Between Onset and
×aminer	İ	Immediate Cause (Final disease or condition resulting in death) a. Complications of lapar Due to (or as a consequence of): gallston		ecystecto	omy 101	Death
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
p :	xam	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		_		
xecuted n and - transit		d. X UNPENDED AMENDED TO THE OCCUPANT OF THE				
760, icate be e	Medical	AMENDED 23a,PII,27,per ME g90 IF FEMALE: 23c. If yes, outcome of pregnancy	6 8/18.10 TT		23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 5 Other (\$\frac{1}{2}\$)		gnancy		day Year
. Bo he dea y the a	hys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underly		Long Bidge	obacco use contribute to	
i, P.O.	<u>۾</u>	Sickle cell anemia; hypertensive cardi			s 2 No 3 Prob	
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the flueral director, page 2 should be	Completed	disease; renal failure		24a. Was a autop		topsy findings available ompletion of cause of
Aeco The la cate ha	E O			perfor 1 V Yes	rmed? death? 2 No 1 ✓ Ye	s 2 No
tal Rec	B	25. Was case referred to medical examiner? Hospital:	26 Place of Death (Che			
Physi Physi er this	라	1 Yes 2 No	DOA Other Nu		Residence 6 Other	
Division of pital or Attending Phous after death. eral Director: After tilled in by the funeral	Certification:	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	Zou. Describe i	now injury occurred	
ViSion or Atto	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fact	ory, office building, etc.		Street and Number or Ru	al Route Number, City
Di Hospital of 24 hours a Funeral I	S -	4 Homicide determined (Specify)		or Town, S	itate)	
To the Hos within 24 ho To the Fun completely	Medical	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at one) 2 W Medical Examiner: On the basis of examination and/or investigation, in				
, Y. W. J.	Ř	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor.	th, Day, Year)
to nation		My arm	O.C.M.E.		March 25, 2010	
1	ľ	30 Name and address of person who completed cause of death (Item 23a)	n Stroot Politimas-	MD 21201	·	
Str	ate	Russell Alexander MD. Assistant Medical Examiner 111 Pen 31. Date filed (Month, Day, Year) 32. Registrar's Signature	n Street, Baltimore,	IVID 21201		
Registi		APR 0 1 2010 Charles & Sales		OCME		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 7:05 P M AGNES FRANCES BRADLEY MARCH 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BETHESDA HEALTH AND REHAB. CENTER MONTGOMERY BETHESDA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛣 F Days Director 025-07-5134 105 24,1904 MASSACHUSETTS Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exercited rust by notified at 1X Yes 2 □ No Director MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a 5721 GROSVENOR LA. Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō If Yes, Give Year or Dates: 1 ☐Yes 2 🛛 No Completed by Specify Specify: 3 X Widowed 4 ☐ Divorced "natural", WHITE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. 10 ORAL SURGERY ASSISTANT U.S. FED. GOV'T. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ JOSEPH L. DOOLEY JOSEPHINE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau ROBERTA BOYD/NEICE 4302 SAUL RD., KENSINGTON, MD.20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY SEPULCHRE CEM. 3-25-2010 NORTH ANDOVER, MA. 21. Signature of Funeral Service Liennsee 22. Name and Address of Eacility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final atherosclerotic **Physician** Cardiovascular disease unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) physician and s the bunal-trans Due to (or as a consequence of): attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an Poon 1 □Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, nours after death.

neral Director: Af 24 hours a completely To the within 2

Baltimore, Maryland 21215-0036

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number howdy D43121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHOWDHURY, MD; 15216 DINO DRIVE; BURTONSVILLE, MD 20 866

State Registrar 31. Date filed

NURUL 32. Registrar's Signature 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Month March 22. 6:00 A M Rose C. Boyd 4b. City, Town, or Location of Death Silver Spring 4c. County of Death 4a. Facility Name (If not institution, give street and number, Prince George's Renaissance Gardens at Riderwood Village | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, June 6, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Mary Tand 077-10-6542 1 M 2 KF Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2x No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 USA 3112 Gracefield Road PVT18 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 TxNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elementary Teacher Education 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellen R. Murray William J. Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 Greenhill Way, Silver Spring, MD 20904 19a. Informant's Name/Relationship (Type. Print)
James T. Boyd / Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kingston, New York St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 21. Signature of Fune Service 500 University Blvd. West, Silver Spring 20901 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, be cause on each line. 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Onset and Death Immediate Cause (Final 1 month Cerebro Vascular Accident disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? nditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 14 hours after death. Funeral Director After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

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Funeral

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death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "hodical Expringer Laut La retified at once.

Baltimore, Maryland 21215-0036

funeral

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Physician/Medical

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Certification: To

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29a. Certifier

IF.	FEMALE:
	b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
Par	t II. Other significant con
	Osteoporosis

1 Tes 2 ₹ No 27. Manner of Death 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number D0036716 29d. Date signed (Month, Day, Year) March 22, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Kundrat, MD 3110 Gracefield Road, Silver Spring, MD 20904

State Registrar 32. Registrar's Signature

To the Hospital within 24 hours a To the Funeral D

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary		tificate of		-	Reg. No.	10	10527
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath 20, 201	Year	3. Time of Death
	/Medic		Ruby Lee Beach					March			10:30 A M
	Examin	er	4a. Facility Name (If not institution, give st Holy Cross Hospit			4b. City, Town, or Silver	r Location of Death Spring		4c. County	y of Death gomer	у
	Funeral Director		5. Social Security Number 6. Sex 1□	7. Age (la	n yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	th 17, Ye <i>ar)</i> 15, 192	9. Birthp Cour 2 Vir	place (State or Foreign ntry) ginia
	pu "		Usual Residence of Decedent 10a, State 10b. County	10	c. City, Town or Loc	nation				1	0d. Inside City Limits
	a-f sho	ctor	Maryland Montgome		Silver						1 □Yes 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 12201 Remington D	rive		10f. Zip Code 20902	2		10g. Citizen of USA	What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is in close Event, but in a natural and once.	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Eve Armed Forces? 1		Vas Decedent of H Yes, specify Cuba □Yes 25€No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ce - Americack, White, of	etc.
Maryland 21215-0036	in 72 ho n "natur Action	Completed by	15. Decedent's Educa (Specify only highest grade	completed)	(Give I	lent's Usual Occup kind of work done OO NOT use retired	during most of work	ing	16b. Kind of B	Business/In	dustry
212	d with glene er tha	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	maker			Own H	ome	
nd	be file tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last)	-1			18. Mother's Name			те)	
yla	d Men narke	၉	Wilton Avery Beau		401-14-11-	- 4 1 1 (01				Ctata 7	Codal
Mai	d 2 sh Ith and 27 is n traun		19a. Informant's Name/Relationship (Type Eugene H. Beach,			,	and Number or Rur ingston R				
Baltimore,	Pages 1 an ent of Hea nt: If item 2 ry or other		20a. Method of Disposition 1 ABurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	`	20b. Place of Dispos cemetery, crem Highland Ce	sition (Name of			20c. Location	- City or To	own, State
Balti	permit. F Departm Importar any Injur		21. Signature of Funeral Service Licenses	Colo	F	Name and Addre	. Collins	Funera	1 Home,	Inc.	na, MD 20901
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the	e death. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	- ODI II	Approximate Interval Between
Line	Physician	ł W	Immediate Cause (Final disease or condition		ulmonary						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co							
	LAdillillei	F	Sequentially list conditions, b.	Coronary	Arterie	Disease				_	
$\overline{}$	uted d ansit	Examiner	Sequentially list conditions, if any leading to him solution cause. Enter Underlying Cause (Disease or injury that initiated events	Comment of the state of the	4						
o,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):						
68760,	rtificate b ng physici as the bu	edical	d.								
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	c. If yes, outcome of particles of Live birth 2 December 2 Decembe	Fetal death 3	Ectopic pregnand Other (specify)	гу			ate of deliv	very Day Year
ls, P.	res that t signed by be detar		Part II. Other significant conditions cont		ot resulting in the ur	nderlying cause giv	en in Part I.				the cause of death?
Ö	w require been si should t	eted							~		
		Completed by	Congestive Heart	rallure				24a. Was auto perfo	psv	prior to co death? 1 🗆 Yes	opsy findings avallable ompletion of cause of 2 122 No
Vital	Physiclan: Th this certificate al director, pag	Be (25. Was case referred to medical examiner?			104	26. Place of Deat	th (Check only	one)		
of	Phys	<u>P</u>	1 ☐ Yes 2 ☑ No		2 ER/Outpatien		4 🗀 Nursing H		idence 6 O		ify)
	Attending Phirr death. ector: After thiby the funeral (rtion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Yo	ear) Injury	Wor	rk?]Yes 2 □ No	200. 200050	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division	of or Attendiate after death.	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, stre Specify)	eet, factory, office		28f. Location (City or To	Street and Nurr wn, State)	nber or Run	ral Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1		camination and/or in						
	To the To the comp	Me	29b. Signature and title of certifie	Λ	10	29c. Licens D633			29d. Date sign March 2		
	20		· Mr	/ /	1 N					_,	
			30. Name and address of person who cor Irina Ruban, MD 15				r Spring,	MD 209	10		
	Sta Registr		31. Date filed (Month, Day, Year) NAR 23 2010	32 Registrar's	Signature	20					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Month 21 12:40 P™ March Marian A. Ballantine 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House-Montgomery Hospice Derwood 8. Date of Birth 5. Social Security Number 6. Sex 1 ፟ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) Min. Hours 12/23/1920 Oh 10 280-16-9432 89 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No MD Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20853 United States 13209 Superior Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Unknown Bertram Fetterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Charles J. Ballantine-husband</u> 13209 Superior Street Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 24 1 Number 1 Number 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, MD of Heaven Cem. vice License 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral 10 East Deer Park Drive Gaithersburg, MD 20877 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between 23a. Part 1 shock Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate name. From Inderlyin Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗓 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) tal 1 🗆 spice 8a. Date

Physician Medical Examiner Examine the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/

Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Director

Funeral

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physician and the burial-transit attending p for use as t the ed by t signed b Jas certificate

Division of Vital Records, P.O. Box 68760

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29a. Certifier

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1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant at time of death g ☐ Unknown	5 Utner (specify)	
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Part I.	23
Lung Cancer			

1 Yes 2 No	Hos	spital:
27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation		28a. Date of (Mont
3 Suicide 6 Could not b 4 Homicide determined	е	28e. Place buildir

Inpatient 2 🗌	ER/Outpatient	з 🗀 і	DOA Other: 4 I Nursing H	ome 5 Residence 6 X Other (Specify) Hospic			
of injury h, Day, Year)	28b. Time of injury	M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
of Injury - At home, farm, street, factory, office ng, etc. (Specify)				28f. Location (Street and Number or Rural Route Number City or Town, State)			

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.							
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					

I who	//	wheet	CRNP

R115/08 March 21, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occ

6001 Muncaster Mill Road Derwood, Maryland 20855 Diane Ruckert, CRNP,

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 03-24-2098 7 30 FM **Physician** Luise Bennett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harkord Havre de Grace Citizens Care Center 8. Date of Birth (Month, Day, June 8, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 💢 F 86 403-62-5815 9923 Germany Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Havre de Grace Maryland Harford **Funeral Director** 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or United States of America 129 Francis Street 21078 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: White 1 □Yes 2 No Specify. ģ 3 Nidowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, I'm M College (1-4or 5+) Cashier Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Anna Vomel Paul Josef Duft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24210 Pimula Ct., Laytonsville, Maryland 20882 19a. Informant's Name/Relationship (Type. Print) Michael Bennett (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
RA Ferris & Co Inc Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03-25-2010 West Chester, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21 123 S. Washington St. Havre de Grace, Maryland Signature of Funeral Ser 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ardio Vascular **Physician** 710 ym resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Surglom 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) william 032609

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

1108 Revolution St. Harn De Gran

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Milian mo

Kommyden

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Items 23aPtI,II,25 per me, 1902 04/95/2010dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2210 /Medical 4a Facility Name (It not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DYID MIDIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) An yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🔽 F Moleton (Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in the Collidar and Once. or items 23a or 28a-f show, 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ILU S' Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ne Specify: Specify: <u>გ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Production Ker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname) Be MSIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20772 MIMS DR. Upperluarlboire allmore Tark husbank 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Bechel, 1 Burial 2 ☐ Cremation 3 Removal from State 20-10 North Canolina 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wiseman Fineral Home LITIC AUGH PLace, Camp Spilings IVID 21. Signature of Funeral Service Libensee 4000 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Acute Per 1 conitis complicating Upper Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Gastrointestinal Bleeding Examiner Percutaneous Endoscopic Gastrostomy Tube Leak Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (r as a consequence of): Examiner week and Dislodgement Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit CERTIFICATION APPROVED BY MEDICAL EXP Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 2 1 No □Yes Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Deep Vein Thrombosis on Coumadin, Alzheimer's Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be aminer? Hospital: Other: 4 \sum Nursing Home 1X Yes 2 1€ 160 To the mosphisms within 24 hours after death.

To the Funeral Director: After this of the Funeral Director After this of the Funeral directors. 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier 🛮 🚾 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #101 Climba, 140 20735 AVC. Berusa 7100 Old Branch axmi 31. Date filed (Month, Day, Year) State Registrar APR 05 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jane Hoffman Clawson March 24 2010 6:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Somerford Place Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/14/1914 Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 579-05-7783 95 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 'natural', or items 23a or 28a-f shov dical Examiner must be notified at Director MD Washington Hagerstown 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 901 Potomac Avenue US Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 if Yes, Give Year or Dates: White 1 ☐ Yes 2K No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

16a. Decedent's Usual Occupation
16b. Decedent Usual Occupation
16b permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturany Injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Secretary Refrigeration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Allan Clevidence Marv Ellen Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P. O. Box 1267, Hagerstown, MD 21741-1267 William P. Young, Jr./Per Rep 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Smithsburg Crematory 03/26/2010 Smithsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Due to (or as a consequence of): **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 TYes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2□ No 1 ☐ Yes Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Assite Live 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury To the Hospital or Attendil within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MY HCD

State Registrar 31. Date filed (Mo

Degistrar's Signature

ddress of person who completed cause of death (item 23a) (Type, Print)

hedird Compos begandon mo

ORIGINAL

041667

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17^{Day} 2010 ear MARCH 5:00 P M PETER CUNNINGHAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 16404 VILLAGE DRIVE UPPER MARLBORO Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC. 17 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 Q M 2 □ F Months Hours SOUTH CAROLINA ື້1923 Director 86 250-28-6441 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland ms 23a or 28a-f sho must be notified at Director PRINCE GEORGE'S UPPER MARLBORO MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 16404 VILLAGE DRIVE 20772 ural", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 2 NoARMY Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify: BLACK Specify: "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) 12th TRUCK DRIVER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic even ၉ HENRETTA BOYKIN SAM CUNNINGHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SADIE H. CUNNINGHAM/WIFE 16404 VILLAGE DRIVE UPPER MARLBORO, MARYLAND 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD VETERANS CEMETERY 4/2/2010 CHELTENHAM, MARYLAND Signature of Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPERTENSION Medical resulting in death) Due to (or as a consequence of): Examiner ACUTE KIDNEY FAILURE Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to lor as a consequence of sician and burial-transit Exam resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria e Hospital or Attending Physician: The law requires that the death certificate be et 24 hours after death.
2 Hours after death.
5 Funeral Director. After this certificate has been signed by the attending physicia leted filled in by the funeral director, page 2 should be detached for use as the bur Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2X☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 욛 1 Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Hosp within 24 hor To the Fune completed fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) MARCH 22, 2010

CR 5

State 31. Date filed (Month, Day, Year)
Registrar MAR 2 4 2010

IVAN ZAMA

9200 BASIL COURT # 200 LARGO, MARYLAND 20774

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year Physician/ John S. Cosby, Jr. March 16, 0918 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's County Hospital Cheverly If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Min 1 X M 2 □ F Director 579-18-0011 DC Ja<u>n.</u> Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Upper Marlboro 1 X Yes 2 ☐ No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20774 312 Ridgely Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Oceanographer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Helen Steward John S. Cosby, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Ridgely Court Upper Marlboro, Md. 20774 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Doris Cosby/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 01, cemetery, crematory or other place)
Maryland
eterans Cemetery 1 X Burial 2 Cremation 3 Removal from State Cheltenham, Maryland 4 Donation 5 Other (Specify) 2010 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Lice se 4001 Benning Rd. NE 20019 Washington, DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ ATA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a nonsecuence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed^a death? Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No Certificate: To 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28c. Injury at 28d. Describe how injury occurred injury Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🖫 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature/ 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheverly UD 20785

Registrar DHMH 17 Rev 7/2009 HOSPIta

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#5. PerFHPGC3-26-10cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12 Bay MARCH 2010^a **CURRY** 5:16 P S. ELOISE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Upper Marlboro 1200 Windermere Court 8. Date of Birth (Month, Day, OCT • 9 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Days Hours Min. Virginia 78 Director 1931 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Upper Marlboro 1 💢 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20774 1200 Windermere Court death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 72 hours after Maryland 21215-0036 Black 1 ☐ Yes 2 🛛 No Specify: Specify: "natural", 3 XWidowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Government Psychologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James H. Shelton Sr. Eloise Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 20785 5705 Carlyle Street Cheverly, Maryland Joseph Pruden/Nephew Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland Lincoln Cemetery 3/19/10 4 ☐ Donation 5 ☐ Other (Specify) Ft. J. B. Jenkins Funeral Home Funeral Service Licensee 22. Name and Address of Facility 7474 Landover Road Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 🗓 No Month Day Year Pregnant at time of death signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ HYPERTENSION Division of Vital Records, The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed HYPERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 🗌 Yes 2**X**□ No Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) $1 \mathbf{X}$ Yes Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) ပ္ 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer (Month, Day, Year) 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 MD13318 March 19, 2010

CR 5

State Registrar

DHMH 17 Rev 7/2009

12158 Central Avenue Mitchellville, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee M.D.

Andrew J.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department	artment of Health and I tificate of Death		2010	10535			
			Decedent's Name (First, Middle, Last)	outo or Bouti	2. Date of Dea	Reg. No C	3. Time of Death			
	Physicia Medic	al	Mary Lou Crump		Month March	15 2010				
,	Examin	er	4a. Facility Name (if not institution, give street and number) Fox Chase Nursing and Rehabilitation	4b. City, Town, or Location of Death Silver Spring	n	4c. County of Death Montgome	ry			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 TF 89 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Day Oct. 3	h 9. Birth (, Year) Cou. 1920 Sout	nplace (State or Foreign ntry) h Carolina			
Б	now at	_	Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Loc	eation			10d. Inside City Limits			
nylan	a-f sh	cto					1 ☑ Yes 2 ☐ No			
Je M	or 28	Ö	DC N/A Washing	10f. Zip Code		10g. Citizen of What Cou				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		Funeral Director	5508 Chillum Place, NE	20011		United Stat	-			
				Vas Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri				
9 5	or it	Completed by F	Armed Forces? If	Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	Black, White,				
)03 Irs aff	ıral", I Exa		3 ☐XWidowed 4 ☐ Divorced If Yes, Give Year or Dates.	Yes 2 X No Specify:		Specify: B1	.ack			
5-6 2 hou	"nati edica	plet		ent's Usual Occupation	kina	16b. Kind of Business In	idustry			
121 File 7	than	mo	Elementary/Seconday (0-12) College (1-4 or 5+)	O NOT use retired)	9	77 -1-1 0-				
\(\frac{1}{2}\)	Hygie Ither Int, th	n l	17. Father's Name (First, Middle, Last)	ealth Aide	/Fi+ 1 di-t-ti-	Health Ca Maiden Surname)	re			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Higeine. Important: If item 27 is marked other than "natural", of any injury or other traumatic event, the Medical Examione.		5	Wilson Edwards	Fannie		Maiden Sumame)				
any	and N is ma auma			g Address (Street and Number or Rui						
e, N	Health em 27 ther tra			Chillum Place, N						
mor	ent of F nt: If its ry or of			natory or other place)	Date 2 / 2 0 1 0	20c. Location - City or T Landover, M				
alti	partm porta y inju		profit in the pr	Name and Address of Facility Mc						
m 8	8 = 6		Joanna E Elsberry	7400 Georgia Ave.	, N.W. V	Wash., DC 20	012			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between			
	ysicia/		Immediate Cause (Final disease or condition Duodenal Adenocal	cinoma			Onset and Death			
	Medical kaminer		resulting in death) Due to (or as a consequence of):							
e.		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):							
Box 68760 death certificate be executed	physician and the burial-transit		Cause (Ulsease or limitury that initiated events resulting in death) Last Due to (or as a consequence of):							
De ex	sician burial		Such to the death and the such as a							
760 icate b	phys s the	ē	d							
Sertif	attending ph I for use as th	2	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of deliv	/ery			
Box 687 death certifica	e atte	Physician/Me	1 Yes 2 XNo 4 Pregnant at time of death 5	Other (specify)		Month				
P.O. I	signed by the a	Phy	g Unknown Part II. Other significant conditions contributing to death but not resulting in the un	adarkina sausa aiyan in Bart I	00 - 5111		64.410			
S, P.	gnec be d	by	Place in Other Significant Conditions Contributing to death but not resulting in the di	idenying cause given in Fart i.		es 2 No 3 Probably 4X Unknown				
ord requ	should I	lete			24a. Was a	an 24b. Were auto	opsy findings available			
ABecords, The law require a state has been side a strong left of the law require a strong left of						prior to completion of cause of death?				
<u>—</u>	certificate rector, pag		25. Was case referred to medical	26. Place of Death (Chec	1 Yes	2 XNo 1 Yes	2 ⊔ No			
Vita ysicia	is cer direct	To B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	_ Other:		lence 6 Other (Specif	v)			
of Figure	ter th		27. Manner of Death 1	28c. Injury at work?		ow injury occurred				
ion	eath. or: Ai the fu	ijica	2 Accident Investigation 3 Sulcide 6 Could not be	M 1 ☐ Yes 2 ☐ No						
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach		Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)			tion (Street and Number or Rural Route Number, or Town, State)				
Spital	hours Ineral d filled	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.							
the H	within 24 hours a To the Funeral I completed filled		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, d	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
70	1		29b. Signature and title of certifier	29c. License number D52261	;	29d. Date signed (Month, 03/21/201				
	le		20 Name and address of parties with a small study of the state of the			55,21,201				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Segal, M.D. 1517 Hugo Circle, Silver Spring, MD 20906									
	Stat Registra	e ar	31. Date filed (Month Day Year) 2010 2. Registrar's Signature	الما						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Tze Hsiong Cheung 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day March 17, 2010 1747 hrs Medical Examiner Tze Hsiong Cheung 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince Georges Hospital Cheverly 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Davs Director Country) China 08/28/1955 578-92-4912 1 χ M 54 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 X No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? $\bar{\Box}$ 805 Royal Crescent 20850 Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X No Yes Asian If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed Specify 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Entrepreneur Financial Industry 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Chun Chu Kong Tin Fuk Cheung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bin-Yong Cheung - Son 7th Street. #1021, NW. Washington, DC 20001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State George Washington Cem. 04/05/2010 Adelphi, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Linenses m00463 Part I. Enter the disease, or compligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or Injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical attending physician a UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available After this certificate has been 24a Was an prior to completion of cause of autopsy 2 No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Driver in vehicular collision Mar 17, 2010 n 24 hours after death.

The Funeral Director: A sletely filled in by the fu Natural 1 Yes 2 V No Pending 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) Addison Rd./ Martin Luther King Jr. Ave., Seat Pleasant, determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 18, 2010 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD Assistant Medical Examiner 2. Registrar's Signature 31. Date filed Arth. D arks Execus. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 12:30 P^M /Medical John Mark Cable March 19. 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gaithersburg Wilson Health Care Center Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director 80 04/13/1929 Tennessee 408-38-6823 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County show ed other than "natural", or items 23a or 28a-f show event, the Medical Expression must be nutflied at 1 X Yes 2 □ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Russell Avenue 20877 United States 12. Was Decedent Ever in U.S.

Armed Forces?

1 ™ Yes 2 □ No 1957 —
If Yes, Give Year or Dates: 1978 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore. Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S._Army Crypto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental if Health and Menta item 27 is marked Joel C. Cable Annie Rogers ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan C. Bell (Sister) 401 Russell Avenue Gaithersburg, Maryland 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t jo March 20 Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Euneral Service Lice ober 10 East Deer Park Drive Gaithersburg, MD. 20877 Approximate Interval Between Sinset and Death 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Leart failule. List only one cause on each line. Imme 1.16 Cause (Final disease or condition ilure to Thrive **Physician** week resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day ned by the a e detached for 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 1 □Yes 2 □No 9 Dinknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown icate has been si Gaut. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate structi 1 ☐Yes 2 ☑No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

of Vital Records, To the Hospital or Attending Phys
within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral dir Division

C

29b. Signature and title of certifier IV. Robert Burschback MID. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

04115

Name and address of person with completed HBALH, MLB

201 RUSSELL AVENUE CAITHERS & LURG, MID

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep	ertment of Health and Nertificate of Death	Mental Hygiene Reg. No. 2010	10538
Physic		1. Decedent's Name (First, Middle, Last) Irene Kenton Chambers		2. Date of Death Month Day Year	2:19/1/M
/Medi Exami		4a. Facility Name (If not institution, give street and number) 3579 Poplar Neck Road	4b. City, Town, or Location of Death	4c. County of Dea	ath
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday 1 Age 2 F 86 Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Bi	rthplace (State or Foreign ountry) aryland
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Caroline P	ocation reston		10d. Inside City Limits 1 □ Yes 2 ☒No
h with the 23a or 28	Funeral Director	10e. Street and Number 3579 Poplar Neck Road	10f. Zip Code 21655	10g. Citizen of What C	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 ☑ No Specify:		
within 72 ho liene.	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) ultry Grower	ing 16b. Kind of Business	
uld be filed Mental Hyg rked other	To Be C	17. Father's Name (First, Middle, Last) Charles V. Kenton	e (First, Middle, Maiden Surname) da Emma Lubba	.	
and 2 shot salth and 1 salth and 1 self salth and 1 self self self self self self self self			ling Address <i>(Street and Number or Rur</i> 7 Oriole Dr., S		
Pages 1 annot of He ant: If item		1 Apputat 2 Li Cremation 3 Li Removal nom State	osition (Name of ematory or other place) er Cemetery 3/2	Date 20c. Location - City of Preston.	
permit. Departition of the permit of the per		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Framptom Funera		
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	hyly mun	. /	Approximate Interval Between Onset and Death
Examiner on sale of the sale o	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. Direction Day	TI	whe	6 mg
cate be executed physician and the burial-transit	dical Exa	Due to (or as a consequence of): d. Hyper Hus; in	1		10 42
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of do Month	elivery Day Year
w requires that been signed b	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute of	to the cause of death? Probably 4 🗆 Unknown
ician: The law re certificate has be ector, page 2 sho	Completed			autopsy prior to death? 1 □ Yes 2 No 1 □ Ye	utopsy findings available completion of cause of
ysicial is certi	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ ✓ □ Hospital: 1 □ Inpatient 2 □ ER/Outpatie	Othor:	h <i>(Check only one)</i> ome 5 Residence 6 ☐ Other <i>(Sp</i>	ecifu)
Attending Physician: r death. sctor: After this certifica	ertification: T	27. Manner of Death 1 1		28d. Describe how injury occurred	sony
ital or Atturs after de al Directo led in by ti	i O i	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or F City or Town, State)	Rural Route Number,
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	ledical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2	nvestigation, in my opinion, death occur	red at the time, date and place, and du	e to the cause(s)
To with	Σ	29b. Signature and title of certifier Mulatre Com	29c. License number	March 25	
		30. Name and address of person who completed cause of death (Item 23a) (Type Mrc Grace Free Clery MD 30 3	D21388 Cellins Hurs	hick med 216	43
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature NAR 2 4 2010	Me		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DONNA **JEAN** CORBIN 22 PM 2010 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NICOMIC 34/13644 PENINS4LA If Under 1 Year | If Under 24 Hrs Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Days 10/19/1963 Maryland Director 214-52-0322 46 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Somerset Crisfield 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2980 Apes Hole Road 21817 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 White 1 Yes 2 X No 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Home Health Aid Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elworth Raymond Hall, Jr. Ellen Jane Justice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 William James Hall (Brother) 2980 Apes Hole Road - Crisfield, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of E Important: If ite 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rehobeth Baptist Cemetery 03/25/2010 Rehobeth, MD 21. Signature of the rad Service License Robert H. Bradshaw, Or. 22. Name and Address of Facility
Bradshaw & Sons Funeral Home anyi 306 W. Main St. Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or iinjury Due to (or as a consequence of): Examin death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-t Physician/Medical use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 D No Certificate: To 1 MInpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

P.O. To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, Division of Vital

Box 68760

State Registrar (Check

only one

3

HAR 23 2010

ause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HERWOOD Month 95 Medical 4a. Facility Name (if not institution, give street and number) Examiner 46 City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min 220-52-5543 Director 61 MD Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDWashington Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 21740 10g. Citizen of What Country? Funeral 102 E. Baltimore Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 Never Married 2 Married ģ 1 ☐ Yes 2 💆 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Warehouse Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sherwood George Dougherty Sr. Anna May Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code 40 Elizabeth Street, Hagerstown, MD 21740 Helen Smith / Sister Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Smithsburg Crematory | 03/25/2010 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Mall Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Seev dure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir death certificate be executed Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 - 140 2 4 1 🗌 Yes Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☐ No Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

le Funeral Director: Aff
bleted filled in by the ful 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the course of the 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 100611 1101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 emell 10 31. Date filed (Mont) State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 23 2010

32. Registrar's Signature

Thomas U. Joseph M.D. 50 West Edmonston Drive Suite 207 Rockville, MD. 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11.20PM 2010 Marjorie Irene ELGIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boonsboro
|| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April 29 Fahrney Keedy Nursing Home
5. Social Security Number 6. Sex 7. Age Washington

9. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 77 1932 Maryland Director 217-28-5215 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than "natural", or items 27 is marked other than 2000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 27 No Maryland Washington Fairplay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8302 Reichard Road 21733 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 No Specify: 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Community College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Daniel Webster Moats Ethel Irene Moran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul P. Elgin - Husband 8302 Reichard Road, Fairplay, Maryland 21733 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 3/24/10 |Hagerstown, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Minnich Funeral home ∡15 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician lete to (or the a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U. derlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy certificate performed 1 ∐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pendina death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ 07-27-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD Khalid M. Wascem 1126 MD Ct. Opal 31. Date filed (Month, Day, Year) legistrar's Signatur State MAR 25 Registrar

Marsoniel-Elgin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Expridite reast be notified at once.	b		Never Married 2 ☑ Marr □ Widowed 4 □ Divorced	ied 1 🔀 Yes 2			1 □Yes		Specify:	,,		Specify:		
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ore	of He			Method of Disposition			Place of Disp	osition (Na ematory or o	me of other place) !	Date	20c.	Location - City	or Town, State	
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Balt	permit. Departr Importa any Inju		21.	Signature of Funeral Service I	Licensee RAN Cours			22. Name a		•	ome, P.A.	47 Hy	39 Balt attsvil	imore A	venue 20781
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Division of	Attendi death. ctor: A	fica	3	3 ☐ Suicide 6 ☐ Could n	not be Tage Place of	l Injury - At ho	me, farm, s			23 2 110	28f. Location	(Street a	and Number or	Rural Route Nur	nber.
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	To the Hos within 24 h To the Fun completely	Me	29b.	Signature and title of certifier		1		29	c. License i	number		29d. E	ate signed (Mo	onth, Day, Year)	
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	cti	-	30. 1	Name and address of person	who completed cause	of death (Item	23a) (Type	, Print)				-	/	/	
-	ا رـ		_	Frederick Thom				e Hig	nway,	Annapo	olis, MD	214	01		
	Stat		31. [Date filed (Month, Day, Year) MAR 9 2 2010	32. Reg	istrar's Signa	ture								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13^{ay}2010 Year MARCH 7:55 A EARLE 0 GEORGE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES HYATTSVILLE 5410 76th AVENUE Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 131-18-9135 1**X** M 2 □ F Months Days Hours Min. (Month, Day, Year, Ountry) NEW Director 82 21 YORK 1927 Usual Residence of Decedent 28a-f shov at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified PRINCE GEORGE'S HYATTSVILLE MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a USA 5410 76TH COURT 20784 items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ within 72 hours after ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give BLACK "natural", Specify: 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene is marked other tha GOVERNMENT POSTAL 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CELESTE GOULBOURNE **GEORGE** EARL permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HYATTSVILLE, MARYLAND 20784 5410 76th COURT WENDY GREENLEE/DGT 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 NBurial 2 Cremation 3 Removal from State WOODLAWN CEME 3/19/10 BRONX, NEW YORK 4 Donation 5 Other (Specify) 21. Signifure of Funeral Pervice Licensee 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the decase, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ ATRIAL FIBRILLATION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYPERTENSIVE CARDIOVASCULAR DISEASE Sequentially list conditions, if a y, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a son suquenes of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit COLON CANCER Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 \ No 2 No Yes 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

NEELAAM ASHAI

filed (Month, Day, Year

MAR 2 & 2010

4410

32. Registra s Signature

D48213

74TH AVENUE LANDOVER HILLS, MARYLANS 20785

MARCH 19, 2010

10-02437

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Ethan Emmanuel Ferrier

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		1- For State Registrar		C	ertific	ate of	Death					Reg. N	D.			
Physic		1. Decedent's Name (First, Midd	le,Last)							1	2. Date of D	eath			3. Time of Death	-
<i>l</i> ledical Exam	ine	Ethan	Emman	uel	Fer	rie	_				Month March 2	Day 27, 201			0925 hrs	
		4a. Facility Name (if not institution	on, give street and n	umber)			b. City, To	wn, or L	ocation o	of Death			c. County o	f Death		_
		Laurel Regional Hosp	ital				Laurel					1	Prince G	eorge	e's	
Funera		5. Social Security Number	6. Sex	7. Age (In yrs	last bir	thday)	If Under	1 Year	I If Linds	er 24Hrs.	8 Date of			-	thplace (State or	_
Director		214-87-7393			. 1001 211	,	Months	Bays			1			Foreig	ın	
			1 M 2 F			Yrs.	2	2			1/25	5/20	10	Co	untry) $ ext{MD}$.	
*		Usual Residence of Decedent														
W an		10a. State 10b. County MD Princ	e George			or Location									10d. Inside City Limit	
and sho	ا ا		e deorgi	= 3	Ld	urel	_								1 X Yes 2 N	0
Maryland 28a-f show any 1 at once,	120	10e. Street and Number					10f. Zip C	ode				10g. Ci	tizen of Wha	at Cour	ntry?	_
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eath ritem	uneral	1 X Never Married 2 M	arried Armed F	orces?			s, specify (140-	White,		carringian, black,	
rer de	╽╙	3 Widowed 4 Div	1 Yes orced If Yes, Give Yes	2 X No		1	Yes 2X	FI NA						B1	ack	
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	팀	17. Father's Name (First, Middle,	Lost)					140	0.00.00							
THE THE	ျပ							18					Surname)			
D 21215-0036 should be filed within 72 hou and Mental Hygiene. 7 is marked other than "main natic event, the Medical Exa	Be	Jean Emmanu							_Ci	ndy	Lamy	7				
Shoul shoul	ြို	19a. Informant's Name/Relations		fathe	r 195	o. Mailing	Address	(Street a	and Num	ber or Ru	ral Route N	umber, (City or Town	, State,	Zip Cod 20708	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygierthen. teath and Mental Hygierthen. Tri marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Jean Emmanue	1 Ferrie	,											aurel,MD	
Baltimore, MI Baltimore, MI permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum:		20a. Method of Disposition 1 Burial 2 Cremation	3 Pemoval fr			of Disposit ory or othe	ion (Name er place)	of ceme	etery,	!	Date	20c.	Location - (City or	Town, State	
Pages ent o		4 Donation 5 Other Sc			hes	a pea	ke C	rem	n .	3/30	1/201	d B	elts	zi 1	le,Md	
Balti Separtin Importa		21. Signature of Funeral Service							of Facility	,	, 20.	9 2.5			10,110	_
Baltimore, MI Baltimore, MI permit. Pages I and 2 s Department of Health an Important: If item 27		NID. A.	- Up			BHI	LIP	D.R	RNIS	rDi	FUNE	RAL	SER	ΊC	E, P. A.	_
Physician	\vdash	23a. Part I. Enter the disease, or	complications that co	aused the deat	h. Do no	t enter the	mode of d	LUIII	ID1a uch as ca	BIX ardiac or r	ZO S1 espiratory a	TVE	r Spi	rin	Approximate Interval	0
/Medical		failure. List only one cause	on each line.											. 4	Between Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Acute Due to (or as a	bronch		eumon	ia								Death	_
			h	consequence	OI).											
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	of):									-		_
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tox 68760, leath certificate be executed a stending physician and for use as the burial - transi	Physician/Medical	X UNPENDED	AMENDED 23a	PII.27	, per	m.E	e903	5/3	/10	тт						
8760, tificate be ng physic as the bur	₩.	IF FEMALE:	23C. 11 yes, C	account of brei	griancy							23	d. Date of de	elivery		-
68' ertifi eding	ian	23b. Was decedent pregnant in the past 12 months?	I I LIVE D	irth		Feta	l death	3	Ectopic	pregnanc	у		Month	Da	ay Year	
Box 6 e death cer the attendii ed for use a	sic	1 Yes 2 No 9 Unki		ant at time of d	eath 5	Othe	er (Specify)					1				
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P.O.					resulting	in the uni	deriying ca	use give	en in Pan	τι.					ne cause of death?	
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Phy er this	ို	1 Yes 2 No 27. Manner of Death				ime of Inju					lome 5			Other:		
Division of Vital Records, rat or Attending Physician: The law requirers after death. al Director: After this certificate has been side in by the funeral director, page 2 should be	Ë	1 X Natural	28a. Date of (Month,	Day,Year)	20D. I	ime or inju	1 I .		at Work?	- 1	id. Describe	how inju	ury occurred			
Sio otten deatl ctor:	äŧ	reliai	igation						2 1							
in b	ij		not be	of Injury - At h	ome, far	m, street,	factory, off	ice build	ding, etc.	. 28	f. Location or Town,		nd Number	or Rura	al Route Number, City	٦
pital Ours	Certification:	4 Homicide determ	nined (Specify)								or rown,	Jiale)				4
Division of Vital To the Hospital or Attending Physician. within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowled	ige, deat	th occurre	d at the tim	e, date	and plac	e, and du	e to the cau	ise(s) an	d manner as	stated	I.	٦
o the	Medical	one) 2 Medical Exam	niner: On the basis o	f examination a	and/or in	vestigatio	n, in my opi	inion, de	eath occu	urred at th	e time, date	and pla	ice, and due	to the	cause(s)	
1 F S F S	ž	29b. Signature and title of certifier					29c. Lic	cense ni	umber			29d. I	Date signed	(Mont	h, Day, Year)	۲
'		his his	· NO				0	.C.M.E	E.			Mar	ch 28, 20	10		
		30. Name and address of person v	vho completed carre	of death /Itca	1 2321											4
	ľ		t Medical Exam			Street	Baltimo	re. MF	2120)1						
C4	ate			istrar's Signati			=======================================	-,	20		·					4
	rar	31. Date filed (Month, Day) Year)	10	A a	As ,	10 Al	9									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2325 per mergy 120 begaring to Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 5:45 A M Caro1 Estelle Givens MARCH 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day, Y Social Security Number 6. Sex 7. Age (In yrs. last birthday) 65 yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Alabama 424-58-1960 1945 Director M<u>ar</u> Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 72 East North Ave. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🔯 No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Essie Belle Bafford Richard Clemons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7818 Sharpsburg Pike, Boonsboro, MD 21713 C. Marshelle Stotler/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Smithsburg Crematory | 3/24/2010 Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Sign to e of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ons, t and Death Physician/ disease or condition 11184 Medical resulting in death) Due to (or as a consequence of): Right Heart Failure and Vytorin Therapy for Examiner Hyperlipidemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine (or as a consequence of executed 11666 the attending physician and hed for use as the burial-tran that initiated events Due to (or a a consequence of) resulting in death) Last CERTIFICATIVAN APPRIORES BY MEDICAL EXAMINER Physician/Medical or Attending Physician: The law requires that the death certificate be of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) Yes 2 No Unknown be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should Is 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2000 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 🗆 Yes 2 🗆 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

all

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22<u>2010</u> Physician/ Month Year VINCENT GORDON MARCH SR. 00:17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 8. Date of Birth (Month, Day, Yea FEB. 8 1 If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. 1**X** M 2 □ F Days Country)
MARYLAND Director 215-26-3024 79 1931 Usual Residence of Decedent show e filed within 72 hours after death with the Maryland ital Hygiene. "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Numbe 10f, Zip Code 10g, Citizen of What Country? Completed by Funeral 5420 OLD CRAIN HIGHWAY 20772 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: BLACK 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumation. 10th HORSE CARETAKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ROBERT GORDON MARGARET SIMMONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VINCENT GORDON JR./SON 3910 MT. PLEASANT ROAD WALDORF, MARYLAND 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) RESURRECTION CEMETERY 4/1/2010 CLINTON, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dabetes 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 XN 1 Yes 2x No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DU6478

Box 68760

P.O.

Records,

Division of Vital

State

4 2010 Registrar

Patern 7501 32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Surratts 12el

Clinton-MD 20735

10-02147 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alonzo Lydell Graham State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Medical Examiner 0410 hrs March 17, 2010 Alonzo Graham Lvdell 4a. Facility Name (if not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death S/B Baltimore Washington Parkway Greenbelt Prince George's 5. Social Security Number If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral 7. Age (In yrs. last birthday) If Under 1 Year Months Director Davs Min. 07/24/1975 77-02-4796 1 X M 2 F 34 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits DC Washington 1 X Yes 2 No or 28a-f show other than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at once, 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 608 Emmanuel Court, N.W. #102 U.S.A. ā 20001 uneral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 4 Divorced of Page 14 September 2015 April 1 September 2015 April ũ 3 Widowed 1 Yes 2 No specify Specif Black <u>م</u> 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Metro - WMATA timore, MD 21215-0036 Mechanic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnny H. Graham Be Bertha Green 19a. Informant's Name/Relationship (Type, Print) ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emmanuel Court 608 #102, N.W. Bertha Graham/Mother If item 27 Washington, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Cremation 3 Removal from State crematory or other place) 1 X Burial 2 Triangle, Virginia 3/24/2010 vantico National Cemetery Donation 5 22. Name and Address of Faciliforald Taylor II Funeral Home 0583 Middleport Lane, White Plains, Maryland 20695 23a, Part I. Enter the disease, or compl cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medic I a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions

Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last hysician/Medical UNPENDED AMENDED IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 🗸 Other; Scene 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred 1 Natural Mar 17, 2010 Driver auto fixed object collision 0000 hrs 1 Yes 2 V No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) S/B Baltimore Washington Parkway, Greenbelt, Md. determined (Specify) Major Road / Highway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Death

29d. Date signed (Month, Day, Year)

March 17, 2010

10 +1

and transit

ned by the attending physician detached for use as the burial -

page

this

After

Director:

Medical

State Registrar

24 hours Funeral

To the within 2

The law requires that the death certificate be executed

Box 68760

Records, P.O.

Division of Vital

DHMH 17 Rev 1/2001 OCMF 2006

29b Signature and title of certifier

31. Date filed (Month, Day, Year)
MAR-2 2 2010

and manner stated

Assistant Medical Examiner

32. Registrar' Signatule

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month Arthur Julian GOLDBERG 10:30 P M March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House Montgomery Hospice Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Months Davs Hours Min. (Month, Day, Year, 579-54-2141 67 **Director** 19 Washington Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Rockyille 1 ☐ Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20855 United States 5613 Lake Christopher Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Amarried 1 Tyes : 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white "natural" 3 Widowed 4 Divorced Year or Dates. Viet Nam injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than, iould be filed within 7 nd Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dentistry Dentist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Saks Samuel Goldberg permit. Page 1 and 2 should be Department of Health and Mer Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20855 5613 Lake Christopher Drive, Rockville, MD Linda Goldberg, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/25/10 Judean Memorial Gardens Olney, MD 21. Signature of van ra Se ice Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home MO 1008 254 Carroll St., NW, Washington,
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Congestive Heart Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consecuence of if any leading to immedicause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Other (specify) s been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has b page 2 sl autopsy certificate 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) n 24 hours after deau.

• Funeral Director: After this ce noleted filled in by the funeral director. Hospital မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 22, 2010 D 0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD Bindi Joseph, M.D. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 **Physician** ROBERT LEE GILBERT, II MAR 16 9:08 P^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min. 1 ★M 2 F **Director** 288-78-7257 28 MARCH 16,1982 OHIO Usual Residence of Deceden death with the Maryland 10a State 10h. County 28a-f show 10c. City. Town or Location 10d. Inside City Limits Examinar quet ba notified at Director 1 Yes 2 No OHIO SUMMIT RICHFIELD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 3493 HAWTHORNE DR. 44286 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2000 filed within 72 hours after 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married ir than "natural", or i Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify. 3 Widowed 4 Divorced Specify: ŽŎ10 WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) 12 U.S. MARINE DEFENSE 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ROBERT LEE ဂ္ဂ GILBERT CATHY **EMCH** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau ROBERT LEE GILBERT/FATHER 3493 HAWTHORNE DR., RICHFIELD, OH 44286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-27-2010 RESTLAND CEMETERY BRIMFIELD, OHIO 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A Manhrusa M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GUNSHOT WOUND TO HEAD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) the signed by 1 I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 □No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Tyyes 2 □ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 2 Accident 1 XYes 2 🗆 No MAR 8 2010 5:30 BATTLE FIELD 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide IVO BALA MURGHAB AFGHANISTAN 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 8 10 3 ME 65453 (FL) 2-4-1 ARMED FORCES INSTITUTE OF PATHOLOGY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY D. MONAGHAN CDR USN MC ROCKVILLE MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Lee Jane HOFFMANN MARCH 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 8. Date of Birth
(Month, Day, Young)
April 19 . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign).1<u>925</u> Days 1 🗆 M 2 🖾 F 84 211-12-3670 Director Pennsylvania Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 Stonecroft Court USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. white "natural", Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) community clinic secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dallas Roth Barbara Leiby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelley Linpinski - daughter 417 Becker Dr., Pittsburgh, Pa. 15237 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 3/26/10 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME halul 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to jor as a consuluence of Exami attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed death? 21 No _ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 npatient 2 ER/Outpatient 3 DOA 1 Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) garitown WH-3 580 Northern Are MI)

DHMH 17 Rev 7/2009

State Registrar 32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Melvin Edward Hutchinson March 16. 2010 0750 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's County Hospital Cheverly 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day Ye 1 🛣 M 2 🗆 F Days Hours Director 75 577-42-3910 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director or 28a-f 1 X Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1738 Bay Street SE 20003 United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 9 Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: African 3 → Widowed 4 □ Divorced Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Truck Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ethel Taylor Melvin James Hutchinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra 5605 Coolidge Street Capitol Heights, Md. 20743 Catherine Kinchens/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
Heritage
Memorial Cemetery March 22, 1 Burial 2 Cremation 3 Removal from State 4 Donation_5 Other (Specify) Waldorf, Maryland 2010 21. Signature of Funeral Service Licer 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. Part 1. Euter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Myocardial Infarction Sequentially list conditions, if my hearing to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy certificate ha 1 🗌 Yes 2 🗆 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🛣 No 은 1 Inpatient 2 A ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Division of Vital Records, P.O.

State

d title of certifier

EJIAKA 7325AHANEOVE 32. Registra

who completed cause of death (Item 23a) (Type, Print)

Medical

29a. Certifier (Check

only one) 29b. Signature ar 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Year MARCH 13 5:34 PM Physician/ HOPKINS III Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S LANHAM 9325 FONTANA DRIVE 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8, Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min Months FEB" 14 Y21947 NEW JERSEY 1 x M 2 □ F 63 156-34-5052 Director Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director 1x Yes 2 No PRINCE GEORGE'S LANHAM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20706 9325 FONTANA DRIVE 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No ARMY If Yes, Give within 72 hours after death Black, White, etc. 1 Never Married 2 Married Specify: BLACK ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) COMMUNICATION SPECIALIST GOVERNMENT 12TH Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental Hoof Health and Mental Hitem 27 Is marked of rother traumatic even ၉ OLIVIA REID JOHN HOPKINS JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9325 FONTANA DRIVE LANHAM, MARYLAND 20706 LOVENIA M. HOPKINS/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State CHELTENHAM, MARYLAND Important: If any injury or once. MD VETERANS CEME. 3/31/2010 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the d. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart from the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): PARKINSON'S DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buna Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendion movinals Box 68760 IF FEMALE: 23d, Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) q Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an autopsy performed? Yes 2 XNo 26. Place of Death (Check only one 25. Was case referred to medical Be examiner? Hospital Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28d. Describe how injury occurred 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 27. Manner of Death (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide completed filled in by 4 Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 115 cen terway

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2010 10554

		1- For State Registrar Certificate of Death		Reg. No.	U 1000
Physici		Decedent's Name (First, Middle,Last)	2. Date of De	ath	3. Time of Death
Medical Exami	ner	MARCUS J. HERRION 4a. Facility Name (if not institution, give street and number) 4b. City. To	Month March 16	5, 2010 4c. County of Death	0344 hrs
		Prince George's Hospital Center Cheve		Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		irth(MM/DD/YYYY) 9. Bir	
Director		577 96 1042 1 Months Usual Residence of Decedent		9 1976 Foreign Co	untry) Wash.
' any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
land f show	or	Md. Prince George Fort Washing	ton		1 Yes 2 X No
Mary r 28a- ed at	irec	10e. Street and Number 10f. Zip 0		10g. Citizen of What Cour	ntry?
ith the 23a o notifi	al D	8225 BOCK ROAD	744	U.S.A	can Indian, Black,
eath w items ust be	Funeral Director	1 Never Married 2 Married Armed Forces? If Yes, specify	t of Hispanic Origin? (Specify Yes or N Cuban, Mexican, Puerto Rican, etc.)	White, etc.	
ifter d		1 Yes 2 No 3 Widowed 4 Divorced of Yes, Give Year of Dates:	No specify:	Specify: Blac	: k
nours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual O	ccupation (Give kind of work done ing life. DO NOT use retired)	16b. Kind of Business/I	
36 in 72 h han "r ical E	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)			
-000 J withing spiene.	mo	11th Construct 17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,	Private	2
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	BeC		Ethel L. Her		
21 nould bed Mer is mar	2	Arthur L. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or Rural Route Nu		Zip Code)
MC shind 2 shalth arm 27 raums		William Herrion, Brother 8223 Bock	Rd, Ft Washin		
Ore, es 1 a of Hc If ite		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name crematory or other place)		20c. Location - City or	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify: Glenwood Ceme	etery $3/25/201$	W ashingto	on, D.C.
Bal permi Depar Impo injur		21. ture of Funeral Service Licensee 22. Name and A	ddress of Facility HALLBRO	THERS FUNE	RAL HOME
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of	dying, such as cardiac or respiratory ar	W. Washino rest, shock, or heart	
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds			Between Onset and Death
Jananinici		or condition resulting in death) Due to (or as a consequence of):			
	힏	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit		events resulting in death) Last Due to (or as a consequence of): d.			
60, ate be ex hysician te burial	Medical	UNPENDED AMENDED			
876 tificate ng phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy	23d. Date of delivery Month D	ay Year
Box 687 e death certific the attending r ed for use as th	sicia	4 Pregnant at time of death 5 Other (Specific	_		
D. BC	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying co	ausa diyan in Part I 23a Didt	obacco use contribute to t	he cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the ragher death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detailed.	۵	g and a second and	1Ye		ably 4 Unknown
ords, w requir s been s should b	Completed		24a. Was		opsy findings available
eco re law te has ge 2 sl	E D		autop perfo	ormed? death?	ompletion of cause of
Vital Rec ysician: The his certificate director, page			Place of Death (Check only one)	2 No 1 Ye	s 2 No
Vita hysich this ce	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DO/	Other Nursing Home 5	Residence 6 Other:	
n of ding Ph. After tl		Makural Makura Makural Makural Makural Makural Makural Makural Makural Makural	Subject sho	how injury occurred	
Siol Attend death cector: by the	Cati	2 Accident Investigation	T Yes 2 V No		
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Apartment Complex	or Town, S	Street and Number or Rur State) on Place SE, Washingt	
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tir			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.			
FSFS	ž	29b Signature and title of certifier 29c L	icense number	29d. Date signed (Mon	th, Day, Year)
		DINULIM	D.C.M.E.	March 16, 2010	
R 2		30. Name and address of person who completed cause of death (Item 23a)	reet Baltimore MD 24204		
1	ate	24 Date filed (Marth, Day Very) 22 Begintrade Signature	reet, Baltimore, MD 21201		- 3
Sta Regist		MAR 2 & 2010 August 18 Signature			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Raymond Edward Hooper Physician/ Mayrch 21, Day 2010 Year 5:40 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3210 N. Leisure World Blvd., #205 Silver Spring Montgomery 9. Birthplace (State or Foreign Country) **Pennsylvani**a Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6 Sex . Age (In yrs. last birthday) **Funeral** Days 199-24-1839 Hours Au Gonth, Pay, Y12930 1 € M 2 □ F 79 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 3210 N. Leisure World Blvd., #205 12. Was Decedent Ever in U.S Armed Forces? 1 → Yes 2 → No If Yes, Give 1952–199 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ If Yes, Give 1952–1954 Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", White Specify: 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) r than " the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Dental Health Dentist is marked other Be Page 1 and 2 should be filed a ment of Health and Mental Hy ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Magdaline Della Held Raymond Edward Hooper, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3210 N. Leisure World Blvd., #205 Silver Spring, MD
20906 Patricia L. Hooper / Wife item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once. Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) March 26, 2010 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia f Funeral Service Lice 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901 21. Sign Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Concestive Heart Failure
Due to or as a consequence of): Medical resulting in death) Examiner Mitral Valve Regurgitation Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year 5 Other (specify) 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 \square Yes 2 X No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Yes 2 x No 1 ☐ Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 🗶 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my mowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. edical Examiner: On the basis of ex ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, Neath occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature e of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 21, 2010 D38888 use of death (Item 23a) (Type, Print) s of person who co hpleted MD 6410 Rockledge Drive, Ste. #2, Bethesda, MD 20817 Harry . Bigham, 31. Date filed (MNTARY, 2

State

Registrar

Registrar's Signatur

Z. S. C. Carlle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#20lopenFH,3/30/10,BMW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Blanche G. Hall 03/19/2010 1255 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F Director 218-30**-**3757 88 09/23/1921 MD Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits show 10b. County traumatic event, the Medical Examiner must be notified Director 1 Yes 2 No MD 28a-f Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 23a 6325 Damascus Road 20882 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 2X No 1 ☐ Never Married 2 ☐ Married ē Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify þ 3X Widowed 4 ☐ Divorced "natural" Black Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygienn Important: if Item 27 is marked other that any injury or other traumant. 6th Private <u>Domestic Worker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Henry Chase Katherine P. Lincoln 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia A. Benjamin - daughter 11236 Minstrel Tune Drive, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Mar. 23 Date 2010 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Ardent Cremation Svs 2/23/10 Hanover, MD 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility 21. Signatur f Funeral Service L Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or commications that caused the deat shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of di , such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a conseque P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year 5 Other (specify) signed by the a t be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other signification t conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 3 Probably 4 Unknown 1 □ Yes 2 □ No been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s has certificate 2 2 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ပ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu death. 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

completely

To the within 2

29a. Certifier

29b. Signatu

(Check only one)

Ahmed Heshmat

Medical

31. Date filed (Month, Day, Year) MAR 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

007

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	State of State of State of Registrar	f Maryland / Depa Cert	artment of H		tal Hygiene Reg. No	ZUIL	10557	
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Kourtney	Ho	1 4b. City, Town, or	Ma	Date of Death Month Da	ay Year 2010 County of Death	3. Time of Death	
) Examine	*	4a. Facility Name (If not institution, give street and nun The Johns Hopkins Hospital		Baltimore If Under 1 Year	City	Date of Birth		hplace (State or Foreign	
Funeral Director		5. Social Security Number 231-45-0955 Usual Residence of Decedent	7. Age (In yrs. last birthday) Yrs.	Months Days	Hours Min. (Month, Day, Year) 15/29/198	Cou	intry)	
Maryland f show ed at		10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits 1 X Yes 2 □ No	
with the Na or 28a be notifi	Director	10e. Street and Number	Glen Burr	10f. Zip-Code 21061		10g. Cit	tizen of What Cou	untry?	
Ind 21215-0036 be filed within 72 hours after death with the Maryland tital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	110 Heatherstone Way 11. Marital Status 1 Never Married 2 M Married 1 Never Married 2 M Married 3 Widowed 4 Divorced 12. Was Decc. Armed Fc II 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 X No		spanic Origin? (Specify n, Mexican, Puerto Rican Specify:		14. Race - Amer Black, White		
1215-0036 vithin 72 hours aff ne. ham "natural", or medical Exami	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th	16a. Decec (Give /-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager			Kind of Business/	Industry	
ind 2121 be filed within tal Hygiene. d other than "	Be	17. Father's Name (First, Middle, Last)		se marrage.	18. Mother's Name <i>(Fir</i> Karen Step	rst, Middle, Maide			
arylcarylcarylcarylcarylcarylcarylcarylc	ျှ	Kermit D. Shields 19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a	and Number or Rural Ro		or Town, State, Z	Zip Code)	
other		Edward E. Hale, Jrhus 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from	20b. Place of Dispo cemetery cren	osition (Name of matory or other place		20c. L	ocation - City or	Town, State	
Baltimore, permit. Pages 1 ar Department of Hee Important: If item any injury or othe		4 Dopatrin 5 Other (Specify) 21. Signature of Funeral Service Liberate Leader	22	ah Mem. Pl 2. Name and Addres 46 N. Wasi		den Fune		e	
√ Physícian	Į,	23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on elimmediate Cause (Final disease or condition	caused the death Do-not entrach line.	er the mode of dyin	g, such as cardiac or re			Approximate Interval Between Onset and Death	
/Medical Examiner	J.	Sequentially list conditions, b.	(or as a consequence of):	vek fe Synd	vome			2 Weeks	
	Exa	cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of):						
30 6 6	Medical	d							
death death e atter	Physician/M	23b. Was decedent pregnant 1 Live	nant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of del Month	livery Day Year	
S, this string and the d	þ	Part II. Other significant conditions contributing to d	leath but not resulting in the u	underlying cause giv	ven in Part I.	_		o the cause of death?	
he law he law age 2	Completed		·	· ·		24a. Was an autopsy performed? 1 ☐ Yes 22 N	prior to death?	utopsy findings available completion of cause of	
f Vital yslclan; Th s certificate director, pa	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2★No Hospital: 1★	Inpatient 2 - ER/Outpatien	nt 3 🗆 DOA Othe	26. Place of Death (Cher: 4 \sum Nursing Home		6 ☐ Other (Spec	cify)	
VISION C Attending PI or death. ector: After th by the funera	ertification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place	of Injury th, Day Year) 28b. Time o Injury of injury - At home, farm, string, etc. (Specify)	M 1 🗀 🗅	?? Yes 2 □ No 28f.	Describe how injude Location (Street a City or Town, State	and Number or R	ural Route Number,	
	edical Cer	29a. Certifier 1 Certifying Physician: To the check only 2 Medical Examiner: On the b	best of my knowledge, death	h occurred at the tim vestigation, in my o	ne, date and place, and pinion, death occurred a	due to the cause(at the time, date a	s) and manner as nd place, and du	s stated. le to the cause(s)	
To the To the Compl	Me	29b. Signature and title of certifier		29c. License	number	29d. Da	ate signed (Monti	h, Day, Year)	
		30. Name and address of person who completed cau	se of death (Item 23a) (Type,			rth Wolfe S	St, Baltime	ore, MD, 21287	
Sta Registra		31. Date filed (Month, Day, Year) 32. F	tegistrar's Signature	Had					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 20 Day GLORIA J. HARRISON 2010 12:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours 1 🗆 M 2 🔀 F Months SEPT 15, Year) SOUTH 218-74-7767 Director 65 Yrs CAROLINA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND HARFORD 1 X Yes 2 No HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 134 VANCHERIE COURT 21078 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES CLERK RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES WRIGHT WILLIEMAE HARRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIMBERLY MCFADDEN / DAUGHTER 125 VANCHERIE COURT, HAVRE DE GRACE, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗀 Burial 2🏋 Cremation 3 🗔 Removal from State R.A. FERRIS & CO. INC 3/24/10 WEST CHESTER, PA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ (0 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Due to (or as a consequence of) resulting in death) Last burialattending physician I for use as the buria Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 1
Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 Yes 2 K No 1 ☐ Yes 2 K No of Vital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 🔯 No မ 1 Prinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funer 1 Natural 2 Accident 5 Pending Division 1 Yes 2 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MNION 501504

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State	OI IVI	arylan	•	artmen <i>tificate</i>				vientai Hy	•	001		10550
			Decedent's Name (First, Name)	liddle, Las	st)				imouto		Journ		2. Date of De		1,000		3. Time of Death
	Physicia Medic		VIOLA		Ρ.	JOHI	NSON						MARCH	15	^{Day} 2010 Ye	ar	10:20 A ^M
	Examir		4a. Facility Name (if not instit	ution, give	street and nu	mber)			4b. City,	Town, or	Locatio	n of Death			c. County of E	eath	
. 1	,		718 62ND A									IGHTS		_			
	Funeral Director		5. Social Security Number 220-16-4955 Usual Residence of Deceder		ex □ M 2 X □ F	7. Ag	e (In yrs. Ia 82	ast birthday) Yrs.	If Under Months	1 Year Days	If Und Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da JUNE 3	th iv, Year 0 1	927 <u>I</u>	Birthp Count [AR]	lace (State or Foreign ry) 'LAND
	Maryland 18a-f show ntified at	Director	10a. State 10b. Co	unty	GEORGE'	S		y, Town or Loc		HTS						1	0d. Inside City Limits
	with the I s 23a or 2 ust be no	Funeral Di	10e. Street and Number 718 62ND AVE	NUE					10f. Zip	Code	-			J		Coun	try?
9003	1 and 2 should be filed within 72 hours after death with the Manyland if Health and Mertal Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Š	11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 ☒ Divo	rced	12. Was Dec Armed For 1 Yes If Yes, Gi Year or D	orces? 2 X ive		If	Vas Deced Yes, spec				ecify Yes or No- Rican, etc.)			/hite, €	tc.
Maryland 21215-0036	within 72 ho rgiene. ner than "nat ner the Medica", the Medica	Completed	15. Der (Specify only) Elementary/Seconday (0- 12TH		ducation ade completed College (i+)	life. DO	lent's Usua kind of wor D NOT use CTOR	k done di retired)	luring m		ing				ustry
land 2	ild be filed w Mental Hyg narked othe atic event,	To Be	17. Father's Name (First, Mid ARTHUR SELLM					DIKE	STOR	OF C	18. Mo		ne (First, Middle,	Maide		1N I	
	d 2 should alth and Me alth and Me 27 is marler traumati		19a. Informant's Name/Relat	ionship (T)									al Route Numbe	r, City			
Baltimore,	Page 1 and nent of Heal ant: If item ; ury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Otl	ition 3 ☐ ner (Specif	Removal from	n State	20b. Pl	lace of Disposemetery, crem	natory or of	ther place			Date / 2010				
Balt	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral 200	ice Licens	see 2				Name and								
	Physician Medical	20	23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or comp _ist only o	ne cause on e	ach line	the death	REST	r the mode	e of dying	g, such a	as cardiac	or respiratory ar	rest,			Interval Between
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Į	b. ATH	IERO		ROTIC	CARDI	OVAS	CULA	AR DI	SEASE				
092	icate be executed g physician and is the burial-transit	Aedical Exa	that initiated events resulting in death) Last	L	c. Due to	(or as a	a consequ	ence of):									
	ath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			Birth gnant at		Ideath 3 🗌	Ectopic p Other (spe		У				23d. Date of Month		•
ls, P.O.	requires that the de been signed by the should be detached	δ	Part II. Other significant cor	ditions co	ontributing to	death b	ut not resu	ulting in the u	nderlying c	ause give	en in Pa	rt I.					
Division of Vital Records,	The law rec cate has bee page 2 sho	Completed					-						24a. Was auto perfo 1 \square Yes	osy ormed?	Year 1927 MARYLAND 10d. Inside City Limits 1 Yes 2		
ta	ician: The certificate rector, pag	Be	25. Was case referred to med examiner?		Hospital:					26. Pla Other		eath (Chec					
n of V	l or Attending Physician: after death. Director: After this certific i in by the funeral director,	ate: To	1 X Yes 2 ☐ No 27. Manner of Death 1 X Natural 5 ☐ Pe		28a. Date (Mor		y	ER/Outpatien 28b. Time of injury		Bc. Injury work?	at					oecify)	
Divisio	To the Hospital or Attend within 24 hours after death To the Funeral Director: completed filled in by the	al Certificate:	3 Suicide 6 C	vestigation ould not be termined	e 28e. Place		ry - At hor :. (Specify)	me, farm, stre			165 21	NO	28f. Location (S City or Tow			Rural I	Route Number,
	To the Hospi within 24 hou To the Fun er complet e d fill	Medical	(Check 2 Medionly one) 3 Certi	cal Exami fying Nurs	ner: On the ba	sis of ex	kamination	and/or investi	gation, in meath occurr	ny opinior red at the	n, death time, da	occurred a ate and plac	t the time, date a	nd plac e cause	e, and due to te (s) and manner	ne cau as sta	se(s) and manner stated. ted.
	5 × 5 0		29b. Signature and title of ce	Unier	21/11	1				License			1				
J			30. Name and address of per	son who s	Will	M	anth /Itam	222) / Tuno D	_	D 13	374			MA	RCH 18	20)10
2	5		ROBERT WILI	IAMS	M.D. 1	L140	VARI	NUM ST		N.E.	# :	201 W	ASHINGT	ON,	DC 2001	. 7	
	Stat Registra		31. Date filed (Month, Day, Ye		32. F	Registra	r's Signati	arkel									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			ForState	State of Maryla				and Mental Hy	/giene	
			Registrar 1. Decedent's Name (First, Middle, La	041	Cei	tificate of	Death		Reg. No.	<u> 10 0561</u>
	Physicia	ın/	MARY LOU JACKSO	,				2. Date of D Month	Pay 16, 20]	3. Time of Death
-	Medic Examir		4a. Facility Name (if not institution, give			4b. City, Town, o	or Location o	March Death	4c. County of	
٧,) = Xuiiii		Holy Cross Hospi	ital		Silver			Montgo	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yr	s. last birthday)	If Under 1 Year Months Days		24 Hrs. 8. Date of Bi	rth 9	9. Birthplace (State or Foreign
	Director		153-40-7907 1 Usual Residence of Decedent	60 E	Yrs.	Months Days	110010	Min. (Month, D December	31°, 1949 0	maha, Georgia
	and show	 	10a. State 10b. County	10c.	City, Town or Lo	cation		<u> </u>		10d. Inside City Limits
	Manyla 18a-f	rect	MD Prince G	eorge's F	Bowie					1 🙀 Yes 2 □ No
	a or 2		10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	th with ms 23 must	Funeral Director	13019 Silver Mapl			2071			USA	
	r deat vriten iner		11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever in Armed Forces?		Vas Decedent of F f Yes, specify Cub	Hispanic Orig an, Mexican	gin? (Speclfy Yes or No , Puerto Rican, etc.)		American Indian, White, etc.
036	s after al", c	d by	3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates.	-	☐ Yes 2X No	Specify:		Specify:	Black
21215-0036	hour natu	Be Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	lent's Usual Occup	pation		16b. Kind of Busi	ness Industry
21	nin 72 ne. shan " e Me	omp	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	kind of work done O NOT use retired,	<i>au</i> nn <i>g m</i> ost)	or working	Gov	vernment
	d with	3e C	17. Father's Name (First, Middle, Last)	<u> </u>		Teacher				Vermienc
Maryland	be file antal I ked o c eve	To E	Frank L. Jackson	ı. Ir.				er's Name <i>(First, Middle</i> alie Lee Wi		
az	nd Me		19a. Informant's Name/Relationship (1		19b. Mailir	ng Address (Street		er or Rural Route Numb		te Zin Code)
	d 2 shalth a		Rosie Lee Boyles	- Sister				urt, Upper		
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐		o. Place of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location - Ci	ity or Town, State
Ë	Page ment tant: I		4 Donation 5 Other (Speci	fy) Removal from State	iverda1e			03/20/2010	Riverdale	e, Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODGs.		21. Signature of Funeral Service Licen	see Sents-	7	. Name and Addre	ess of Facility dy St	y Johnson & reet, NW, V	Jenkins Vashington	Funeral Home , DC 20011
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the de	eath. Do not ente	er the mode of dyir	ng, such as	cardiac or respiratory a	rrest,	Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition	RESPIRATOR	XY FAILU	RE				Onset and Death
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		er	Sequentially list conditions,	b. METASTATIC		TO LUNG				
	ted Insit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	ESOPHAGEAL						
	execu an and rial-tra	Ex	that initiated events resulting in death) Last	Due to (or as a conse	equence of):		_			
9	cate be executed physician and s the burial-transit	edical		l d						
68760	rtifica ling ph e as th	/Me	IF FEMALE:	00						
Box 6	ath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live Birth 2 F 4 Pregnant at time of	etal death 3		су		23d. Date of Month	
M.	the a	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9 Unknown	ordeath 5 L	Other (specify) _			IVIO ILI	, buy rous
P.O.	that the		Part II. Other significant conditions	ontributing to death but not	resulting in the u	nderlying cause gi	ven in Part I	23e. Did	tobacco use contribu	ute to the cause of death?
S,	uires in sign	ed b						1 🗆	Yes 2 ☐ No 3	Probably 4 X Unknown
Ö	iw req	Completed by						24a. Was		re autopsy findings available or to completion of cause of
Rec	The la	Som							ormed? dea	ath? Yes 2x No
tal	cian: ertific ector,	Be (25. Was case referred to medical examiner?	Hospital:				h (Check only one)		
fΥ	Physi this c	٠ <u>.</u>	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 X Inpatient 2 28a. Date of injury	ER/Outpatien		4 🗀 Nu	rsing Home 5 🗆 Res		Specify)
u o	iding th. After funer	cate	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injur work M 1	ryat k?]Yes 2 □	1	how injury occurred	
Division of Vital Records,	Atten er dea ector: by the	Certificate:	3 Suicide 6 Could not b	28e. Place of Injury - At			100 2		Street and Number of	or Rural Route Number,
Div	tal or s afte al Dire		4 E Homoldo determined	building, etc. (Spec	cify)			City or To	wn, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 K Certifying Phy (Check 2 Medical Exam	sician: To the best of my kno	owledge, death o	ccured at the time	e, date and p	place, and due to the ca	ause(s) and manner a	as stated. the cause(s) and manner stated.
	thin 2:	Me	only one) 3 Certifying Nur. 29b. Signature and tipe of certifier	Practioner: To the best of	my knowledge, c	leath occurred at th	e time, date	and place, and due to the	ne cause(s) and mann	er as stated.
	5.≱ 5 8		235. Signature and the of certifier			29c. Licens D67			29d. Date signed (A 03/16/201	
	10		30. Name and address of person who	completed cause of death (Its	em 23a) (Tune D				,,	
R	20		Dr. Harold V. Law	son, Jr., MD,	1500 F		en Rd.	, Silver S	Spring, Md	20910
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Sign	take!					

DHMH 17 Rev 7/2009

Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

State

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Laron Locke MD.

Assistant Medical Examiner

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JOHNSON 6:12 JANET 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S LANHAM DOCTORS HOSPITAL Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 □ M 2 🛣 Days Hours Months Min JUNE 6 1955 NORTH CAROLINA Director 54 Yrs 577-74-3730 Usual Residence of Decedent shov 10a. State 10b. County 72 hours after death with the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f Yes 2 No MD PRINCE GEORGE'S RIVERDALE 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be Completed by Funeral or items 23a 6353 64TH AVENUE # 20737 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2X Married Saltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. BLACK "natural", 3 Widowed 4 Divorced Specify Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Schnson, id Mental Hygiene. marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH TEACHER AIDE GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ HARVEY LEWIS ODESSA ROYSTER . Page 1 and 2 should b iment of Health and Mei tant: If item 27 is mark 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEON JOHNSON/HUSBAND 6353 64TH AVENUE C3 RIVERDALE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot cemetery, crematory or other place, 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD NATIONAL CEMETERY; 3/22/2010 LAUREL, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ardio Physician/ res pirator disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Metastatic breas Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of that the death certificate be executed y physician and is the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as attending plant of the last as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy
☐ Other (specify) in the past 12 months? Month Day Year Yes 2 🔀 No the 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, or Attending Physician; The law requires 2 No 1 🗌 Yes Completed 3 Probably 4 Unknown page 2 should peen . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy certificate 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of within 24 hours after death.

To the Funeral Director: After of completed filled in by the funer. 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 NO Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier March 16,2010 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenbelt, MD. 20170 Calat

State Registrar MAR 2 2 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 23, 2010 2:50A Ellen Kovatch March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown Washington NMS Healthcare If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X 273-07-3378 97 May 2, Pennsylvania Director 1912 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Berkeley Springs Director WV Morgan 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4511 Pious Ridge Rd. 25411 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Baltimore, Maryland 21215-0036 Specify. Specify: white þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 6 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Estronick Ann Antol ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trauonce. Rd. Berkeley Springs Gary Nelson/nephew 4511 Pious Ridge 20c. Location - City or Town, Sta 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/24/2010 Winchester, VA 22. Name and Address of Facility Rosedale Funeral Home 917 Cemetery Rd. Martinsburg, WV 25 21. Signature of Funeral Service 25404 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner burial-trar Due to (or as a consequence of) the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No 1☐ Yes 2X No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death.

I Director: A
d in by the fu n 24 hours aft ie Funeral Di letely filled ir within 24 hor To the Fune completely fi

Certification: To 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 . Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flaphine bme.

31. Date filed (Month, Day, Year) MAR 2a

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 2010 10:30P M KUMBA KAMARA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE JOSEPH RITCHIE HOSPICE HOUSE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace State or Foreign SIERRA-LEONE 6. Sex 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F OCT. 18 Months ear) 1981 Director 28 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√2 Yes 2 ☐ No MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20781 4909 EDMONSTON STREET SIERRA-LEONE within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian . or Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturary injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NURSE AIDE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 SUSAN KAMARA KAMARA FAYIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13911 EDSALL STREET UPPER MARLBORO, MARYLAND 20772 AYOKUNLE ADLADESELY/FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RESURRECTION CEMETERY 3/27/2010 CLINTON, MARYLAND Jure of Funer Service 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Day to for as a consecurity of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-trans 03/20/10 Due to (or as a consequence of) by the attending physician tached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy requires that the death in the past 12 months?
1 Yes 2 No Day Month Year signed by the a 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s Physician: The law performed After this certificate 2 XNo 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum_{\text{Nursing Home}}\) 1 Nursing Home \(\frac{5}{2}\) \(\sum_{\text{Residence}}\) 1 🗌 Yes 2 No ۵ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death. (Month, Day, Year) injury 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation within 24 hours after deatl the Lunba Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pleted filled in by determined building, etc. (Specify) Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction on To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who co

31. Date filed (Month, Day, Year)

MAR 2 4 2010

am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2010 **Physician** Ethel Louise Lages March 23, 11:25 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5420 Hollow Tree Lane Keedysville Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Dec 27, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □**K**F 75 1934 Virginia Director 220-30-5409 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Eventinar must be notified at 1 ☐ Yes 2 🛣 No Director Maryland | Washington Keedysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5420 Hollow Tree Lane 21756 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: U.S.A. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy Injury or other traumatic event, the Mones. College (1-4or 5+) Key Punch Operator Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Chester Hottinger Goldie Frances Landis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5420 Hollow Tree Lane Keedysville, Maryland 21756 <u>Charles E. Lages / Husband</u> 20a. Method of Disposition
1 Deurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 03/26/2010 Marriottsville, Maryland Crest Lawn Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun val Service Licens e 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 23a. Part1. Enter the disease, or complications the cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Lause (Final **Physician** Mastatic disease or condition resulting in death) Ovarian years /Medical Due t (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ∐ Yes 2 🖬 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Cynthia Kuttner-Sands, MD D47451 March 24, 2010

6H-16

MAR 25 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Kuthner - Sands, MD Hospice of



Registrar

Washington County

Hagerstown,

747 Northern Avenue

Maryland 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 2010 LIM MARC 20 DOMINGO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S UPPER MARLBORO 10249 PRINCE PLACE # 103 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 4 1920 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Min. Days Hours 1 ₹ M 2 □ F PHILLIPPINE 89 558-40-8241 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 Tyes 2 No Director PRINCE GEORGE'S UPPER MARLBORO MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 10249 PRINCE PLACE # 103 20772 USA items 23a by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married CHINESE ō Baltimore, Maryland 21215-0036 12 Yes 2 □ No Specify. 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE RADIO BROADCASTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN UNKNOWN မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau 14005F KORBA PLACE LAUREL, MARYLAND 20707 DOROTHY LIM/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/23/2010 RIVERDALE, MARYLAND RIVERDALE CREMATORY 4 Donation 5 Other (Speqify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atheroselente **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 1 ☐ Yes 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? **⊉** No 1 ☐ Yes 2 400 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home .1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending ospital c.
4 hours after dea... 1. Natural 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

Box 68760 P.0. Division of Vital Records,

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Year MARCH 1 7 Day LOTT 1541 **JEAN** C. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1000 BRIGHTSEAT ROAD #117 P.G. LANDOVER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APRIL 17 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 7 1945 1 □ M 2 □ F 64 N.C. 578 60 3077 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Xres 2 ☐ No LANDOVER MD. P.G. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1000 BRIGHTSEAT ROAD #117 20785 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ∐Yes 2 🕍 No Specify: Specify:BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE MAIL CLERK 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LEVI AMBROSE CAROLYN ANDERSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 BURGESS AVE, ALEXANDRIA, VA. 22305 JACKIE JENKINS/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/24/10 BRENTWOOD, MD. FT. LINCOLN CEM. 4 ☐ Donation 5 ☐ Other (Specify) 20010 of Funeral Service Licenses 22. Name and Address of Facility WATSON F.H. 3435 14th ST.N.W.WASH. DC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage disease or condition resulting in death) Due to (or as a comequence of) pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

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23a

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"natural"

7 is marked other traumatic event, II

Department of Health Important: If item 27 any injury or other to once.

Health and Mental em 27 is marked o

Examiner must

Director

Funeral

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Completed

Be

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21. Sign

Pages 1 and 2 should be filed within 72 hours affer death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

Examine Physician/Medical Be Completed by Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans attending physician for use as the buria s been signed by the should be detached cate has t , page 2 s funeral director, o 24 hours after death.

Funeral Director: A letely filled in by the fu the the

Division of Vital Records, P.O. Box 68760,

•	d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying ca	ause given in Part I.	23e. Did tobacco use contribute to the cause of death?
			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknow
			24a. Was an autopsy findings availab prior to completion of cause or death? 1 □ Yes 2 ⋈ No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		Check only one)	
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO	e 5☑ Residence 6 ☐ Other (Specify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury M		d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office 28	ff. Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occurred iner: On the basis of examination and/or investigation, and manner stated.		

29c. License number

D0650098

Mary land

29d. Date signed (Month, Day, Year)

20235

MD

2010

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EUGENE 31. Date filed (Month, Day, Year) State NAR 2 2 2010 Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAGEE

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 03/20/2010 Ceasar Lewis 1:04 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 18939 Red Robin Terr. Montgomery Germantown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 01/22/1955 1 🔀 M 2 🗆 F 55 **Director** 248-08-8061 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 Xyes 2 No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 18939 Red Robin Terr. 20874 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Ş 1 Never Married 2 XMarried Maryland 21215-0036 If Yes, Give 1 Yes 2X No Specify: "natural", Specify. Completed 3 Divorced 4 Divorced Year or Dates Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Cable Technician Orion Communication Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Charlie Green Rebecca Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Lewis - wife 18939 Red Robin Terr, Germantown, MD 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) Souls Cemetery 3/29/10 Germantown, MD 22. Name and Address of Facility Snowden Funeral Home <u> 246 N. Washington St. Rockville, MD 20850</u> 23a. Part 1. Enter the disease, or a shock, or heart failure. List or plications that caused the death. Po not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death se, or cor Immediate Cause (Final Physician/ disease or condition Metastatic prostate cancer Medical resulting in death) Due to (or as a consequence of **Examiner** Pulmonary embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Oue to (or as a nonsequence or Anemia Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day 4 Pregnant
9 Unknown Yes been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an filled in by the funeral director, page 2 autopsy performed? Yes 2 X No this certificate has 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မ 1 🗌 Yes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifie X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріеть (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signati Atitle of cert P 29c. License number 29d. Date signed (Month, Day, Year) 0060658 0 2

State Registrar 10810 Connecticut Avenue, Kensington, MD 20895

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Adrian Dale Hurley

31. Date filed (Month, Day, Year,

MAR 23

Frank Calvin Laliberte, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1. For State Certificate of De	eath	Reg.	No.	
Physici		Decedent's Name (First, Middle,Last)		Date of Death Month	av Year	3. Time of Death 2056 hrs
ledical Exam	iner	riank daivin Laliberte, Jr.	City, Town, or Location of Death	March 18, 2	010 4c. County of Death	
			City, Town, or Location of Death Goldsboro		Caroline	1
Funeral			Under 1 Year If Under 24Hrs	. 8. Date of Birth(MM/DD/YYYY) g. Bir	thplace (State or
Director			Months Days Hours Min.		Foreig	_{untry)} Virginia
		225-55-2733 1½ M 2 F 20 Yrs. Usual Residence of Decedent		May 19,	1989	"Virginia
/ any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show any 1 at once.	ō	Maryland Caroline Goldsboro				1 Yes 2 No
Maryl 28a-1 d at o	Director	10e. Street and Number 10	f. Zip Code	10g.	. Citizen of What Cou	ntry?
h the		15150 Jarrell Road	21636		U.S.A.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	uneral	1 X Never Married 2 Married Armed Forces? If Yes, s	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	ican Indian, Black,
er dez , or i	щ	1 Yes 2 X No	s 2X No specify:		Specify: Whi	te
urs afl tural'	d by	or Dates:	Isual Occupation (Give kind of v	vork done 1	6b. Kind of Business/l	
5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use reti	red)		
036 vithin ene. rr tha	m	12 Crew m	nember		Fast Food	L
Hygiv d other	ပ		18.Mother's Name	(First, Middle, Mai	iden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	o Be	Frank Calvin Laliberte, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Adv	Victori dress (Street and Number or F	a Crane	North	Zin Code)
MD 2 d 2 shou Ith and P n 27 is n	ř		arrell Road, G			
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental lant: If item 27 is marked or other traumatic event,		20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery,		Oc. Location - City or	
nor ages ont of other		1 Burial 2 Cremation 3 Removal from State crematory or other p		2 2010	01	, Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 X Other Specify: Entombment Greensboro 21. Signature of Funeral Service Licensee 22. Name	and Address of Facility			
		Mar Christina 106	gle and Helfen W. Sunset Ave.	bein Fun Greens	eral Home, boro, Mary	PA land 21639
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.	ode of dying, such as cardiac o	r respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Compressional Asphyxia				Death
. *		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
ecuted and transit		events resulting in death) Last Due to (or as a consequence of): d.				
ब ब	edical	UNPENDED AMENDED				
760, icate be ext physician the burial	.≥।	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
OX 68/ eath certifi attending for use as t	ician	past 12 months? 2 Pecanont at time of death	_	ncy	Month D	ay Year
Box e death c the atten ed for us	(O	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)		1	
P.O. es that the gned by the	y Phy	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		cco use contribute to	
S, P.C nires that signed d be deta	ad by				2 ✓ No 3 Prob	
of Vital Records, ag Physician: The law require this certificate has been sineral director, page 2 should be	Completed			24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
Rec The la icate h	Ë			performe 1 Yes 2		s 2 No
tal Rection: The	Be	25. Was case referred to medical examiner?	26.Place of Death (Check of			
F Vil Physic rathis	P	1 ✓ Yes 2 No lospital 1 Inpatient 2 ER/Outpatient 3			sidence 6 🗸 Other	: Scene
n of ding P h. t After funera	ë	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 28b. Time of Injury FOUND: 28b. Time of Injury FOUND:		28d. Describe how Subject pinned	d beneath vehicle	е
Division al or Attendi rs after death. al Director: A	cat	2 Accident Investigation Mar 18, 2010 2030 hrs		28f Location (Stre	et and Number or Ru	ral Route Number, City
Div tal or rs afte	Certification:	3 Suicide 6 Could not be determined (Specify) Yard			e) ad, Goldsboro, MD	,,
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a	at the time, date and place, and	due to the cause(s) and manner as state	
To the within To the Comple	edical	one) 2 Medical Examiner; On the basis of examination and/or investigation, i and manner stated.	in my opinion, death occurred at	t the time, date and	d place, and due to the	e cause(s)
H \$ H 5	ž	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mor	nth, Day, Year)
		N-M-IM	O.C.M.E.	^	March 19, 2010	
		30. Name and address of person who completed cause of death (Item 23a)	nn Street, Baltimore, MI	21201		
	24	31 Date filed (Month, Day Year) 32 Registrar's Signature				
St Regist		31. Date filed (Month, Day, Year) AR 2 4 2010 Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Alicia Marie March 23, 2010 4:01 P Myers 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 19223 Nick Road Washington Keedysville Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 21, 19 7. Age (In vrs. last birthdav) Months Days Hours 1 □ M 2 1 F 165-10-8573 91 1918 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 【 No Maryland Washington Keedvsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3404 Chestnut Grove Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes X□No Specify Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rivetor and Sealer Aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Nick Maude Mullendore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan M. Keller / Daughter 19223 Nick Road Keedysville, Maryland 21756 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Samples Manor Cem 03/26/2010 | Sharpsburg, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Licenses 7606 Old National Pike Boonsboro, MD 21713 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each ne. Approximate Interval Between Onset and Death Immediate Cruse (Final OCONE disease or condition resulting in death) r as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? perform 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner The law requires that the death certificate be executed

Department of Important: If any injury or once.

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or natural be notified at any or other traumatic event, Ite Medical Exactions must be notified at

Baltimore, Maryland 21215-0036

/Medical

Funeral Director

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Completed

Be

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Physician/Medical Examiner physician and the burial-trans attending p for use as 1 been signed by the should be detached Completed by certificate has b sepital or Attending Physician: Theoris after death.
Ineral Director: After this certificate y filled in by the funeral director, pa Be Certification: To

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

1 Yes 2 No 27. Manner of Death

5 Pending investigation 2 Accident 3 ☐ Suicide determined 4 ☐ Homicide

6 ☐ Could not be

2☐ Medical Examiner:

28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Street, Brandborn, MA 21715

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

And manner stated. 29b. Signature a

29d. Date signed (Month, Day, Year)
March 24, 2010

JH-4 State Registrar

To the Hospital within 24 hours a To the Funeral

29a. Certifier

(Check only one)

MAR 25

32. Registrar's Signature

anno

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#10f.PerFHPGC3-26-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARIR 135 KEITH TYRONE MOORE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S 4023 92nd AVENUE SPRINGDALE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day) **Funeral** Year) Days Hours 1**X** M 2□ F Yrs Director 579-84-5484 51 1958 WASHINGTON, DO NOV. 4 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MD SPRINGDALE PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20774 natural", or items 23a 4023 92ND AVENUE 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ∐Yes 21√∑No Specify BLACK \$ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life, DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 7TH STOCK CLERK PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN DELORES W. JACKSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROCHELLE MOORE/SISTER 4023 92nd AVENUE SPRINGDALE, MARYLAND permit. Pages 1 and Department of Heall Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 3/24/2010 4 ☐ Donation 15 ☐ Other (Specify) RIVERDALE, CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Immune **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 ⊑ 1 ☐ Yes 25. Was case referred to medical examine. Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 1 🗆 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 240 completed cause of death (Item 23a) (Type, Print) 3001 32. Registraris Signature 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19Day 20190r Physician/ Menth 12:51PM Mason Jewelee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral Birthpiaco NC Days Min. February 1 M 2 J 81 Director 227 32 3043 Usual Residence of Decedent "natural", or items 23a or 28a-f shov dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1

Yes 2 □ No Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9590 Crain Highway #216 20772 IISA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Henry McNeil Clara (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9590 Crain Hwy.#115,Upper Marlboro,MD20772 Juanita Taylor/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Southampton Mem Pk 3/26/2010 Franklin, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Funeral Home Inc Jores Alexandria, 4Franklin 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Year Pregnant at time of death signed by the a 1 Yes 2 2 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has page 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending s after death.

I Director: Aff 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital c within 24 hours at To the Funeral D completed filled is Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 753200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surratts Road, Clinton, MD 20735 Wendell Pierson 31. Date filed (Month, Day, Year) 32. Registra's Signa State MAR 2 4 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 14, Day 2010 Physician/ 10:00 AM Otis Mills, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hyattsville Prince George's Thomas Moore Nursing Home 8. Date of Birth (Month, Day, Y July 19 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 → M 2 □ F Days Country) Virgin<u>i</u>a 82 Director 578-26-7025 Yrs 1927 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at by Funeral Director 28a-f 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a 4526 Eads Place NE 20019 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: **Black** If Yes. Give Specify: 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry al Hyglene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Chauffer Private Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Otis Mills, Sr. Mary Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4526 Eads Place NE Washington, DC Claudette E. Mills/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland
National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State March 22. 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Laurel, Maryland 22. Name and Address of Facility Stewart Funeral Home, Signature of Funeral Service Licenses 20019 4001 Benning Rd. NE Washington, DC 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest approx, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequ resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Pregnant at time of death 1 Yes 2 Unknown 9 Unknown rate has been signed by the a page 2 should be detached P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an autopsy perform Yes the Hospital or Attending Physician: thin 24 hours after death.

The Funeral Director: After this certifications. 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: ၉ 1 Tes 2 00 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying/Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tille of cert 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 4922 Lasalle Road Hyattsville, Maryland Sonja Wyche MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

MAR 2 & 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert Francis McCort Sr. March 20, Day 2010 Physician/ 7:25 P Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Arden Courts Assisted Living Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗷 M 2 🗆 F Days Hours April Das Yerr925 277-22-1964 Off Toy) 84 Yrs. **Director** be filed within /z new.

Aental Hygiene.

arked other than "natural", or items 23a or 28a-1 snew.

ratic event, the Medical Examiner must be notified at Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director Maryland Montgomery Rockville 1 Yes 27 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13314 Turkey Branch Parkway 20853 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

Yes 2 \(\square\) No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1943–1946 1 ☐ Yes 2 K No Specify: Specify: White Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Intelligence Officer CIA permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of any injuy or other traumatic even ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Schneider Frank Ronald McCort 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Franklin Avenue C36, Middletown, MD 21769 Daniel McCort / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 21. Sign vure of Funeral Service Licer 23a. Part 1. Enter the disease, or shock, or heart failure. List of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Interval Between Onset and Death Immediate Cause (Final h sician/ Metastatic Prostate Cancer disease or condition 1.5 yr Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been signed to the second 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 2 X No 2 K No 1 Yes _ Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide 24 hours Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) D60050 March 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahrukh Hussain, MD 1396 Piccard Drive, Rocville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NAR 23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH VIOLET MARIE MAY 2010 P^{M} 3:43 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CECIL UNION HOSPITAL ELKTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MARCH 11, Year) 1 □ M 2 💢 F Hours 214-74-8530 Director 62 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 ☐ No MARYLAND CECIL ELKTON 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 365 w. main street 21921 UNITED STATES "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NEVER WORKED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EDDIE MAY FRANCES MARIE MATTHEWS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NOLA EARL / SISTER Page 1 and 2 365 W. MAIN STREET, ELKTON, MARYLAND 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State R.A. FERRIS & CO, INC 03/29/10 4 Donation 5 Other (Specify) WEST CHESTER, PA 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE Signature of Funeral Service Licensee MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical e to (of as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury eumonn Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? After this certificate within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p B 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29c. License number Name and address of person who completed d cause of death (Item 23a) (Type, Print) ElE pa, mo

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:15 P^M 21 2010 Phillip Morgan, Sr March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 421 Horseshoe Road Queen Anne's Oueen Anne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 ☐ F 59 February 18,1951 216-56-1799 Mary Land Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinar man be notified at any Injury or other traumatic event, If a Medical Examinar man be notified at 1 ☐ Yes 2√☐ No Director Maryland | Queen Anne's Queen Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 421 Horseshoe Road 21657 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify Specify: 3 Widowed 4 Divorced Caucasian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Agriculture College (1-4or 5+) 12 HS grad Services Plant Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Easter Turner Marion Morgan Dorothea Ann ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela L. Morgan Wife 421 Horseshoe Road, Queen Anne, Maryland 21657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 DOther (Specify) Greenmount Cemetery 3/25/2010 Hillsboro, Maryland 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Signature of Funeral Service Licenses 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death gastroesophageal Immediate Cause (Final disease or condition resulting in death) iunction **Physician** months /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. 9 Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Rosalyn Juergensus 1650 Orleans Street Johns Hopkins CRBI-G93 Baltimore, Maryland 21231

park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

160203

March 29, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:20 A. M Leon Edward Nichols March 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Hours (Month, Day, Year) May 05, 1933 Country) Director 579-42-7000 76 Browns, Md Usual Residence of Decedent show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 XYes 2 No MA P.G. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1004 Nyanga Avenue 20743 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 7: If Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Driver Trucking Be 17. Father's Name (First, Middle, Last)
John Edward Nichols 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Evelyn Nichols/Wife 1004 Nyanga Ave., Capitol Hgts., Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 03/15/10 Landover, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. and 4925 Burroughs Ave., N.E., Washington, 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Severe Cardionyopathy (On Intra Aortic balloon pump) Medical Due to (or as a consequence Examiner Renal Failure Davs Sequentially list conditions, Examiner any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). Uremic Encephalopathy **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Davs that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Diabetes Mellitus Years Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Syncope 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Coronary Artery Disease After this certificate has I autopsy performed? Yes 2 No Hypertension 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\mathbb{M} \) No Be 26. Place of Death (Check only one) Hospital Other: 2 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation after death Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 3001 Hospital Drive, Cheverly, Maryland

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

James Akras,M.D.

D45341

March 10,2010

20785

10-02488 Raymond North

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day March 29, 2010 Medical Examiner Raymond North 1835 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Route 198 Eastbound Anne Arundel 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or oreign MD Days Director Hours Aug. 29,1950 217-56-4603 59 1 X M 2 F Usual Residence of Decedent any 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges Laurel 28a-f show 1X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Laurel Avenue 20707 United States ō Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 X Married Yes 2X No Specify: White 3 Widowed If Yes, Give Year 1 Yes 2 X No specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Automobile 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Mamie Louise Beville Raymond Talbert North Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3558 D Mt. Ada Drive, Ellicott City, MD 21043 B Gail Ann North/Wife If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, ore. April 2010 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State West Arundel Cremator Odenton, MD Baltimo permit. Page: Department o Donation 5 Other Specify ture of Funeral Sep 22. Name and Address of Facility Columbia Mortuary Services, /M00969 9013 Annapolis Rd., Lanham, MD 20706 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Alcohol intoxication Immediate Cause (Final disease a. Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27,28a-f,perm,E g902 4/7/10 TT physician the burial -XUNPENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed' death? ✓ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Division of Vital uneral director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other4 DOA Nursing Home 5 Residence 6 🗸 Other: Scene this 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day,Year 28b. Time of Injury 28d. Describe how injury occurred Certification: Natural unk 1 Yes 2 X No the Pending Director: Fd 5:30 pm Fd 3/29/10 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be residence 198 East Laurel, MD 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOME O.C.M.E. March 30, 2010 30. Name and address of person who complete cause of death (Item 23a) Assistant Medical Examiner Theodore M. King, Jr., MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed APR

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		-				and Mental H	ygier	ie		
			1 - State RegistraAMENDP1+2p	erMD,3/24/1	.0,BM	W, MOES	rtificate of	Death		Reg. N	10.2011	110	1570
Г	Dhuaiai		1. Decedent's Name (First, Middle,	ast)					2. Date of D Month		Day Year	3. Time	of Death
	Physici /Medic		Louis Pisani						March		2010	5:45	A M
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	r Location	of Death	4	c. County of Deat	h	
A. C.			Shady Grove Ad				Rockvi1				Montgomer		
П	Funeral			.Sex 7.Ag 15x1M2□F	je (In yrs. i	89 Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (Month, I			thplace (State ountry)	e or Foreign
	Director		578-16-1525 Usual Residence of Decedent			OF YES.			Nov. 1	4,19	20 Wash	ningto	n, DC
	and		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside	City Limits
	Mary -f sh	to	MD Montgor	nery	Kens	ingtor	1					1 ∑ Y∈	s 2 No
	the 28a	Director	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Co	untry?	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show ant, the Medical Examinar must be notified at		4225 Franklin S	2 <i>+</i>			20895			IIn	ited Stat	-00	
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. \		Hispanic Or	rigin? (Specify Yes or N n, Puerto Rican, etc.)		14. Race - Ame	rican Indian,	
9	or Ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	Nο						Black, White		
ဗ္ဗ	ral",	d by	3 → Widowed 4 □ Divorced	If Yes, Give Year or Dates:	WWII		I⊡Yes 2——No	Specify:			Specify: Whi	.te	
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and	ntal Hed of	Be	• • •	•							n Sumame)		
Ž	hould d Me mark matic	၉	Giacomino Pisa 19a. Informant's Name/Relationship			10h Mailin	a Addrona (Stroot		ziella Rube per or Rural Route Num		y as Taum State	Zin Codel	
Ma	d 2 sl th an t7 ls i traui		Rachel Pisani			ŀ			Kensington			.ip Code)	
ē,	1 an Heal tem 2	S	20a. Method of Disposition	, Daughter	20b. P	<u>, </u>	sition (Name of natory or other place		Date		Location - City or	Town, State	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Exercites must be notified anone.		1 Burial 2 ☐ Cremation 3					i	3/22/2010	7.1.		- MD	
ቜ	artme ortan injur	- 4	4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice		Gat				3/22/2010 ^{ity} Simple Tr		ver Sprin	ig, MD	-
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			23a. Part 1. Enter the disease or co	mplications that caused	the death	1001					,	Approxim Interval B	ate
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	/Medical		disease or condition resulting in death)	a. VII a Due to (or as			Heamonite	.15				24	
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	g # d	ner	Sequentially list conditions,	Due to (or as	a consecu	ience of):						1 1/2	wke
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68760,	ificate be executed g physician and ss the burial-transit	edical		d. Anem	ia Cr	ronic/	COLIT						
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Вох	atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	Ideath 3□	Ectopic pregnand Other (specify)	у			23d. Date of del Month	livery Day	Year
o	the d y the ched	ysi	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unknown	it tillio oi u	caar 5E	Joiner (specify)						
٠ <u>.</u>	The law requires that the death cert tee has been signed by the attending age 2 should be detached for use a		Part II. Other significant condition	contributing to death b	ut not resu	ılting in the ur	nderlying cause giv	en in Part I	I. 23e. Did	tobacco	o use contribute to	the cause o	f death?
Vital Records,	quires n sigi	d by	Chronic Obstruc	ctive Pulmi	nary	Diseas	se		1] Yes	2 □ No 3 ᡚ Pi	robably 4	Unknown
ဝ	w rec	Completed							24a. Wa	s an	24b. Were au	topsy finding	s available
æ	The far cate has page 2	m							aut	opsy formed?	prior to death?	completion of	cause of
ta		BeC	25. Was case referred to medical	H				26 Place	1 □ Yes e of Death <i>(Check only</i>		√o 1∟Yes	2 □ No	
	Physiclan: this certific al director,	TO B	examiner? 1∐Yes 2∑XNo	Hospital:	ent 2	ER/Outpatien	t 3 DOA Oth	or.	ursing Home 5 ☐ Re		6 ∏Other (Spe	cify)	
Division of	Attending Physician: r death. ector: After this certific. by the funeral director, p	Ë	27. Manner of Death	28a. Date of Inju (Month, Da	ıry	28b. Time of Injury			28d. Describe				
Ö	ath. Af Af	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	y, 70a7	,,		N: Yes 2□	INo				
Š	r Attriber de irecte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine				eet, factory, office		28f. Location City or To	(Street	and Number or Ruate)	ıral Route Nı	ımber,
	italo InsafralDi Redir	S	47										
	To the Hospital or Attendi) within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	of examinat	wledge, death tion and/or in	n occurred at the ti vestigation, in my o	me, date a opinion, dea	nd place, and due to that hat no courred at the time	e cause e, date a	(s) and manner as and place, and due	stated. to the cause	e(s)
	the I	Ned	29b. Signature and time of/certifier	and manner sta	ated.		29c. Licens	o number		204 [Date signed (Mont.	h Day Your	
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	Sta	te.	John Shigo 185	40 Office P	ar's Signat	ture		ery Vi	LILage, MD	<u> 2088</u>	00		
	Registr	ar	31. Date filed (Month: Dev. Year)	10 Centura		Low	Last .						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** Diane Elizabeth Rohol 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Regional Hospital Laurel Laure George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 K F Director 217-44-2583 63 30, 1947 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at 1 ☑Yes 2 ☐ No Director MD Howard Savage 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ò be 20763 23a 8525 Fair Street U.S.A. traumatic event, the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11 Marital Status Black White etc. 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Accountant Bank 1 and 2 should be filed wi Jealth and Mental Hygier sm 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ပ Charles Basil Rohol Elizabeth Ashline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is any injury or other trau Elizabeth Rohol /mother 8525 Fair Street, Savage, Maryland 20763 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility
Donaldson Funeral Home, P.A.

313 Talbott Ave. Laurel, Man

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rest iratory arrest, shock, or fresh failure. List only one cause on each line.

Immediate Cause (inal disease or condition resulting in death)

3. Sepsilon 4 □ Donation 5 □ Other (Specify) Mar 22, 10 Dorsey, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Aspiration Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760, physician a the burial Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.0. 9 I Inknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate has 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 X Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 K ER/Outpatient 3 □ DOA ပ 1 Inpatient this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After t To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated. 29a. Certifier Medical (Check only one) on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D66945 March 18, 2010

State Registrar Laurel Regional Hospital,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Carter, MD

7300 Van Dusen Rd.

Emergency Dept. Laurel, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Bettye Revis March 19,2010 3:55a. [™] 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Laurel Cherry Lane Nursing Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign North Carolina Months Days Hours 1 ☐ M 2 🛣 F 78 246-40-2137 6, July Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Prince George Glendale 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20769 U.S.A. 11000 Forestgate Place 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Per.Dir. National Daycare Assoc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James H.Matthews, Sr. Virgie Powell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexis Revis-Yeoman (Daughter) 11000 Forestgate Pl., Glendale, MD. 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wash.National Cem. 3-23-10 Suitland, MD. 22. Name and Address of Facility Lewis Funeral Home of Furieral Service Kingsee 21. Signatu 311 N.Patrick St., Alexandria, VA. 22314 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Accident disease or condition resulting in death) years Due to (or as a consequence of): Arterio Sclerotic Cardio Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an

Physician /Medical Examiner

death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Physician

/Medical

Examiner

10a State

MD.

Director

Funeral

δ

Completed

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or

filed within 72 hours after death

Pages 1 and 2 should be filed within 72 ho ment of Health and Mental Hygiene. ant: If item 27 is marked other than "naturury or other traumatic event, the Merical I

rtment of Department of Important: If it any Injury or c

3altimore, Maryland 21215-0036

Examine burial-transit attending physician for use as the buria been signed by the should be detached To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director; After this completely filled in by the funeral di Certification:

Physician/Medical IF FEMALE: Completed by Be T_o 27. Manner of Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed? Yes 2 2 No 1□ Yes

25. Was case referred to medical examiner? 1 TYes **≱**∏ No

1 XNatural

29a. Certifier

2 Accident

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation

26. Place of Death (Check only one)

Other: 4X Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

3 ☐ Suicide 6 Could not be determined 4 ☐ Homicide

1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific

29c. License number

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

March 19,2010

D24721

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sadiq, Syed M.D., 14333 Laurel-Bowie Rd., Laurel, MD. 20708

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 2 2 2010



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per me, g902,04/05/2010dhb Certificate of Death Reg. No. 1- For Amend Item 25 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 18 Day **Physician** 2010 3:12 A Joseph Edward Spicer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y) 5/4/1936 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1**X** M 2 □ F 73 Yrs. 579-46-7733 Director Washington D.C. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Ocean Pines MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20 Long Point Court 21811 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2/CKMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced white Health and Mental Hygiene. em 27 is marked other than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CIA Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Virginia Boothe Joseph Hume Spicer မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Long Point Court, Ocean Pines, MD 21811 Susan Spicer / wife permit. Pages 1 and Department of Heal Important: If item 2 any injury or other Once. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State 4 ☐ Donation 3/19/2010 Frankford, DE Cape Henlopen Crem. 5 Other (Specify) Burbage Funeral Home 21. Signature of 22. Name and Address of Facility 108 William St., Berlin, MD 21811 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one caus, in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ATION APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2 5 nours after death.

neral Director: After this certificat
v filled in by the funeral director, ps 1 Yes 25. Was case referred to medical examiner?
1 🕅 Yes 2 📉 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title 30. Name an Berlin MD 21811 11+1

Registrar
DHMH 17 Rev 1/2001

State

SCI-01-123 #S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Robert Norman Sears 603PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OF Baltimore Ltimore HOSPIta Baltimore City Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 D F Hours Min. 06/25/1927 82 127-20-9886 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 10d. Inside City Limits MD Washington Hagerstown 1 🛚 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 200 Avon Road US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married be filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed White 3 X Widowed 4 Divorced Specify: is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) 10College (1-4 or 5+) Aid Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Eva (unk) Campbell Raymond Hatch Sears, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 E. Baltimore St., Funkstown, MD 21734 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Austin G. Rinker / Per Rep 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 03/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Hagerstown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consumence of the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe, page 2 should be rmocardial 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 2 3 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number march 24, 2010

SH 10+1 State

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who comple

Baltimore

ited cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Physician/ Month Lloyd Edward Simmons, Jr. 0114 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number 7. Age (In yrs. last birthday)
57 Yrs. If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Hours 09/13/1952 219-60-4588 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 31 Bethel Street US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Completed by 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bailer Retail Warehouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lloyd Edward Simmons Sr. Mary Catherine Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Simmons / Sister 31 Bethel Street, Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 103/29/2010 4 Donation 5 Other (Specify) Rose Hill Cemetery Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause pleach line. Interval Between et and Death Immediate Cause (Final Pnysician/ ancrea disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown g Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown cate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 **X**No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fune 1 🗹 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 052323 63-24-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M-9 OPal Hagerstown Md. 21740 1126 ourt 31. Date filed (Month, Day, Year) gistrar's Signature MAR 26 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ March 1³, 201⁶ Deborah Michelle Strothers 8:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton 8. Date of Birth (Month, Day, Year) Jan. 17, 1 If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Days 1 - M 2 - F 579-92-0010 Vrs DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2142 Alice Avenue Apt. # 203 20745 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married þ 2 X No 1 Yes : Specify: African American 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Supply Specialist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lucretia Strothers Raymond H. Strothers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ft. Washington, Md. 4213 Payne Drive Lucretia Strothers/ Mother 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Lincoln Memorial Cemetery 1 X Burial 2 Cremation 3 Removal from State March 19, 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 22. Name and Address of Facility Stewart Funeral Home, Signature of Funeral Service 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1. E. ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shools or leart fallure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Cardio pulmona J Due to (or as a con equence of): disease or condition resulting in death) Cardio ay patty Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 💆 No Day Year Pregnant at time of death 1 Yes 2 y 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anoxic brain 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🂢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Coagulapathy 24a. Was an autopsy performed? Yes 2 X No Intra psoas musch 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ည 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 1 Tes 2 No

requires that the death certificate be executed physician a s the burial-t Box 68760 attending pi signed by the a P.O. Records, certificate has page or Attending Physician: Division of Vital nours after death.

neral Director: After the filled in by the funera thin 24 hours at the Funeral C Hospital

Funeral

Director

show

th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Medical Examiner must be notified at

should be filed with and Mental Hygien 7 is marked other th

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

Physician/

Medical

Examiner

Baltimore, Maryland 21215-0036

within 24

State

Medical

29a. Certifier

29b. Signature and title of certifier

Roth him

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARAHIFAR

M.0

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D43446

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

12150

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

3.21.10

Annapolis road Suit 312. Glenn dal MD 20769

DHMH 17 Rev 1/2001

Registrar

10-01519

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Christine Marie		ddy Si 1- For State Registrar	tate of Maryla		artment o		nd Me	ntal H	ygiene	Reg. No.	UII	1038
Physici	an/	1. Decedent's Name (First, Midd	, ,						2. Date of D Month			3. Time of Death
Modical Exami	ner	CHRISTINE 4a. Facility Name (if not institution		SHEDDY		4b. City, Town,	or Location	of Death		y 19, 2010 Yes	of Death	1530 hrs
		201 E. Market Street	, 0	iber)		Snow Hill		TOI DOG		Worces		
Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs. I	ast birthday)	If Under 1 Y		der 24Hrs	. 8. Date of	Birth (MM/DD/YYY)		
Director		222-66-1169	1M 2 X F	29	Yrs	Months D	ays Hou	irs Min.	DEC 2	2,1980	Foreign Cour	ntry) DE
,		Usual Residence of Decedent		Lan- Oir	~							10d Inside City Limits
ow any		10a. State 10b. County DELAWARE SUSS	EX COUNTY	1 1	Town or Locat		H LAK	E DR	. MILE	ORD, DE		10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show d at once.	횽	10e. Street and Number				10f. Zip Code			- 11111	10g. Citizen of W		
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	6694 B GRI	FFITH LAKE	DR.		199	963			USA		
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once		11. Marital Status		dent Ever in U		is Decedent of						an Indian, Black,
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5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	12			нс	ME MAKI	ER			OWN	HOM	3
15-003(Tled within Hygiene. d other tha		17. Father's Name (First, Middle								e, Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	CLATR 19a. Informant's Name/Relations	SHEDDY		19b Mailing	Address (St		LYNN Imber or F		ESSER lumber, City or Tow	n State	Zin Code)
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e, MD 1 and 2 sh Health an item 27 i		20a. Method of Disposition			Place of Dispos crematory or ot	ition (Name of			Date	20c. Location		
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Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		21. Signature of Funeral Service	Licensee			lame and Addre						19966
		23a. Part I. Enter(he disease, or	7 7	MO 1361						BOX 125		SBORO, DE Approximate Interval
Physician Medical		failure. List only one cause	on each line.		. Do not enter t	ne mode or dyli	ig, such as	cardiac o	rrespiratory	arrest, snock, or ne	art	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c		of):							
		Sequentially list conditions,	b									
	je	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	consequence o	f):							
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be executed ician and urial - transi	dical	UNPENDED	d AMENDED									
	Mec	IF FEMALE: 23b. Was decedent pregnant in ti	ho l 🖂 '	utcome of preg	nancy					23d. Date of		
Box 68760 e death certificate b the attending physic	sician/Me	past 12 months?	I LIVE DI	th nt at time of de	oth -	tal death her (Specify)	BEctop	oic pregna	ncy	Month	Da	y Year
Box e death the atte	ysi	1 Yes 2 No 9 V Un			3 Ot	ner (Specify)						
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ords, P.C w requires that as been signed t	g								24a. W			psy findings available
COFC law rehas be	Completed								au	topsy		mpletion of cause of
tal Rection: The Coertificate Sector, page	S	05.11				00 PI	(D	(0)	1 ✔ Ye	s 2 No 1	✓ Yes	2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should t	a	25. Was case referred to medica examiner?	Hospital:	patient 2	ER/Outpatient		Ce of Deat		g Home 5	Residence 6	Other:	Scene
n of V ding Phy After th funeral c	5	1 ✓ Yes 2 No 27. Manner of Death	28a Date of	f Injury	28b. Time of I		jury at Wo	rk?	28d. Describ	e how injury occum		
ion tendir tor: A	gio	1 Natural 5 Pend 2 Accident Inve	ding FOUND: Feb 19, 2		FOUND: 1530 hrs	1	Yes 2	No	Subject a	ssauited		
ivis or At affer of Direc	ertification:	3 Suicide 6 Cou	ld not be 28e. Place		ome, farm, stree	et, factory, office	e building,					l Route Number, City
Di Hospital 24 hours a Funeral etely filled	S	4 Homicide	ermined (Specify)		_					, State) East Market St.,		
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	ical	(Chack only Certifying F	hysician: To the best aminer:On the basis of	of my knowled examination a	ge, death occur ind/or investigat	red at the time, tion, in my opini	date and pond date and ponder and	place, and occurred a	due to the ca t the time, da	iu s e(s) and manner te and place, and c	as stated lue to the	cause(s)
To the within To the comple	Medical	29b. Signature and title of certific	and manner sta	ited			nse numbe			29d. Date sign		
		Will A.	and lon	To the same of the		0.0	C.M.E.			February 2	0, 2010	
		30. Name and address of person										
		Melissa Brassell, MD		A. C.	1	enn Street,	Baltimo	re, MD	21201			
Segie	tate	31. Date filed (Month, Pay, Year)	6 2010 32. Reg	istrar's Signatu	ire .	and						

DHMH 17 Rev 1/2001 OCME 2006

OCME

			1 - For State Registrar Amend	State of M Items 25,27,	aryland / Del 28a-f per	partment of I me g902 0 ertificate of	lealth and 4/05/201 Death	Mental Hy 0dhb	/giene Reg. No.?	10	10588
	Dhysis	ion	1. Decedent's Name (First, Midd					2. Date of De		Year	3. Time of Death
	Physic /Medi		Juanita P	. Tichnell				March	17 20	10	8:45a.M
	Exami	ner	4a. Facility Name (If not institution				or Location of Deat	h	1	y of Death	
1			Moran Manor 5. Social Security Number	Nursing Hom	e ge (In yrs. last birthda		ernport If Under 24 Hrs	8 Date of Bi		Alleg	
	Funeral Director		214-80-9837	1□M 2፟M F	95 Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D Dec. 2	ay, Year) 7 - 1914	Kitz	place (State or Foreign intry) miller, MD
	P.		Usual Residence of Decedent					1000. 2	7,1717		
	arylar show	-	10a. State 10b. County		10c. City, Town or	Location				1	10d. Inside City Limits 1 □ Yes 2 🛣 No
	he M	Director	WV Min	neral	Keys						
	with ya or		20 Hummingb:	ind Ctroot		10f. Zip Code 267	26		10g. Citizen of	USA	ntry?
	rer death with the Marylan items 23a or 28a-f show mr must be notified at	Funeral	11. Marital Status	12 Was Decedent	Ever in U.S. 13	3. Was Decedent of H If Yes, specify Cub		pecify Yes or N			can Indian,
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show fleal Evr. in at must be notified at		1 ☐ Never Married 2 ☐ Mai	ried Armed Forces ried 1 ☐ Yes 2 🖺 If Yes, Give	No	If Yes, specify Cub. 1 □ Yes 2 KS lo	an, Mexican, Puer	to Rican, etc.)		ck, White,	
Maryland 21215-0036	72 hours "natural", clical Eva	d by	3 X Widowed 4 □ Divorced	Year or Dates:					Specia	WIII	
15-	- 7 30	Completed	15. Deceder (Specify only highe	it's Education st grade completed)	16a. Dec	cedent's Usual Occup le kind of work done . DO NOT use retire	nation during most of wor	king	16b. Kind of E	Business/In	dustry
212	withir jiene. r than	E O	Elementary/Secondary (0-12)	College (1-4or	b+)	lomemaker	u)		0	wn Ho	me
b	al Hygid other	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Nar	ne (First, Middle			
/lar	ould be f Mental arked o atic eve	10	Edgar Allen	Barnard			Mabe!	l Cora M	IcRobie		
far	2 should be and Mental Is marked or raumatic ev		19a. Informant's Name/Relations	ship (Type. Print)	19b. Ma	iling Address (Street	and Number or Re	ıral Route Numl	er, City or Town	, State, Zip	o Code)
	ges 1 and 2 should be filed wit to fleath and Mental Hygien if item 27 Is marked other the or other traumatic event, I'm	Ļ	Sally J. Tichi	ne11/Daughte		0 Bobwhit		Keyser,		726	
Baltimore,	tiges 1 int of 1: intite		20a. Method of Disposition 1			position (Name of ematory or other plac	Marc	h 22 10	20c. Location		
Ħ	artme artme ortant injury		4 Donation 5 Other (5			1 Cemetery		10	Swant	ton,	MD
Ba	Sally J. Tichnell/Daughter Sally J. Tichnell/Daughter 240 Bobwhite Drive							neral H er, WV	ome 2672	26	
			23a. Part 1. Enter the disease, o shock, or heart failure. List	complications that cause	d the death. Do not e						Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	COV	whom a	Am (liserse				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	1			111		
	LXaIIIIIei	<u>.</u>	Sequentially list conditions,	b			-	Α.	MEDICAL EXAMIN	ER	
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):			TO OVED B	MEDICALED		
,	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c Due to (or as	a consequence of):		CERTIFICAT	ONA			
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	edical		d							
99	ntifica ng ph as th	Medi	IF FEMALE:					-	1		
Вох	eath certific attending p for use as t	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		☐ Ectopic pregnanc	:V			ate of deliv	- ,
0	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death 5	Other (specify)			M	onth	Day Year
σ.	uires that the de signed by the a d be detached f	H.	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use con	tribute to ti	he cause of death?
of Vital Records,	quires n sign ild be	d by	p. frial	f-bollation		ngestive a	Jew 1	10	Yes 2 □ No	3 ☐ Prol	bably dunknown
၀	aw requir s been s should	Completed	Lailar.	, Le	st le	Lemoston	18	24a. Was	an 24b.	Were auto	opsy findings available
R	The law ite has age 2 s	J O	1			(See 4) 414		auto perfo	psy ormed?	prior to co death? 1 ☐ Yes	impletion of cause of
ital	ysician: The is certificate h director, page	BeC	25. Was case referred to medica examiner?				26. Place of Dea	1 □ Yes th (Check only o	_/	1 La Yes	2 LJ NO
<u>></u>	hysic his ce I dire	일	1 X Yes 2 1No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpati	ent 3 □ DOA Oth	er: 4 Alursing H	ome 5 Res	dence 6 🗆 Otl	her (Specit	fy)
	ffe ne	in o	27. Manner of Death 4-☑ Natural 5 ☐ Pendir	28a. Date of Inju g (Month, Da	y, Year) Injury	Worl	k?	28d. Describe Subject	how injury occur bumped	leg	on wheel-
isic	I or Attendi after death. Director: A I in by the fu	icat	2 Accident investigned investigned a large service and a large se	Har chyz.			Yes 2 No	chair			
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	4 ☐ Homicide determ		ury - At home, farm, s c. <i>(Specify)</i> ing Home	treet, ractory, office		City or To	wn, State) 25 esternpo	701 S	al Route Number, Shady Lane
_	spita hours neral y fillec		29a. Certifier	g Physician: To the best	of my knowledge, dea	ath occurred at the ti	me, date and place	e, and due to the	cause(s) and m	nanner as s	stated.
	he Ho n 24 I ne Fu pletel	Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner st	f examination and/or	investigation, in my o	opinion, death occu	rred at the time	date and place,	and due to	o the cause(s)
	Vithi To th	Σ	29b. Signature and title of certifie			29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
				en//	Þ	121	244		3/22	120	10
	.5		30. Name and address of person			e, Print)		21522			
	Sta	to	Jesus Tar 31. Date filed (Month, Day, Year)		Broadway ar's Signature	Frostbu	rg, mn	21532			
	Registr	_	APR U 5	2010 Sauce	~ B. A	arked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		artment of H			giene _{Reg. No.} 2 (110	10589
	Dhusisis	/	Decedent's Name (First, Middle, Last,						2. Date of De Month		Year	3. Time of Death
	Physicia Medi	cal	Eleanor Olga Ta						March	16	2010	1240PM
	Examir	ner	4a. Facility Name (if not institution, gives Memorial Hospi				4b. City, Town, or Ea-S:		1		y of Death	-
Ī	Funeral		5. Social Security Number 6. Sec	7. A9	e (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th 73, Year) 1915	9. Birthp	lace (State or Foreign
	Director		214-22-3714 Usual Residence of Decedent		5	95 Yrs.			Feb. 2	3, 1915	<u> </u>	Maryland
	yland f shoved	ctor	10a. State 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City Limits
	ne Mar or 28a notifi	Funeral Director	Maryland Caroline 10e. Street and Number		Ric	igely	10f. Zip Code			10g. Citizen of	What Coun	1 ☐ Yes 2 🛣 No
	with the 23a c	eral	12798 Crouse Mill	Rd.			2166	50		U.S.		uy:
•	death items		11. Marital Status	12. Was Decedent I	Ever in U.S.	. 13. W	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ	
	al", or	d by	1 ☐ Never Married 2 ☐ Married 3 🌃 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No		☐ Yes 2 🛣 No			Specif		
400	2 hour "natur	plete	15. Decedent's Ed (Specify only highest grad	ucation		16a. Deced	ent's Usual Occupa	ation Juring most of wor	kina	16b. Kind of I		_
Jeanor (rithin 7 iene. r than	Completed by	Elementary/Seconday (0-12)	College (1-4 or 5	5+)	life. DO Bookk	NOT use retired)	J		011 0	ompan	v
日日	filed wall Hygi	Be	17. Father's Name (First, Middle, Last)			DOORIC		18. Mother's Nar	ne (First, Middle,			<i>y</i>
<u>ة</u> 2	uld be I Ment narke natic e	잍	Elmer Engles						A. Lup			
lor	I 2 sho Ith and 27 is r		19a. Informant's Name/Relationship (Type Colleen Scharf	e, Print)			g Address (Street a 8 Crouse				. ,	
Taylor, E	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Xcremation 3	Damas val fram Stata	20b. Pla				Date	20c. Location		
Į į	t. Page tment ttant: I jury o		4 Donation 5 Other (Specify,		Ches	er eak	sition (Name of natory or other place e Cremati	lon Mar	.17,2010	Cheste	r, Ma	ryland
Ba	permit Depar Impor any in		21. Signature of Funeral Service License	en-		22.	Name and Addres	and Helfe	enbein F	uneral	Home,	PA land 21639
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only on	ications that caused	d the death	. Do not ente	r the mode of dying	o, such as cardiac	or respiratory ar	rest,	mary	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pneum	NON							Onset and Death
	Medical Examiner		resulting in death)	Lue to (or as	a conseque	ence of):	ut fin	lure				
		iner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to as	a conseque	ence of):	W/ 10	IINVE				
	ecuted and -transi	xam	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as	a conseque	MHC						
9	ate be executed bhysician and the burial-transit	dical Examiner	L,	1.								
6876	rtificate ing phy e as the	Med	IF FEMALE:									
Box 6	eath certificat attending ph	Physician/Me	in the past 12 months?	3c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 🗌 Fetal	death 3	Ectopic pregnanc Other (specify)	у			ate of delive onth	Day Year
	the de by the ached	hysi	1 ☐ Yes 2 🔁 No 9 ☐ Unknown	9 Unknown								
РО	es that the des signed by the s		Part II. Other significant conditions con	ntributing to death b	out not resu	lting in the ur	nderlying cause giv	en in Part I.				e cause of death?
prds	requires been sig	Completed by							24a. Was			osy findings available
360	he law tte has	omb							autor	osy rmed?	prior to cordeath?	mpletion of cause of
<u></u>	ding Physician: The Is h. h. After this certificate h. funeral director, page	Be	25. Was case referred to medical examiner?	ospital:				ace of Death (Che		2 110		2 - 110
ž.	Physi rthis o	5: To	1 ☐ Yes 2 █ No ☐ ☐ 27. Manner of Death	1 A Inpati	ıry :	ER/Outpatien 28b. Time of	t 3 DOA Othe	4 L Nursing H	ome 5 Resid			
5	anding sath. or: Afte	ficat	1 🗷 Natural 5 🗆 Pending 2 🗀 Accident Investigation	(Month, Da	y, Year)	injury	work'	? Yes 2 □ No	-= -			
Division of Vital Records	or Attending I after death. Director: After In by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubul	ury - At hon c. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 2 Certifying Physi	cian: To the best of	my knowle	dge, death o	ccured at the time,	date and place, a	nd due to the ca	use(s) and man	ner as state	d.
	thin 24 the Fu the Fu	Med	(Check 2 Medical Examin only one) 3 Certifying Nurse 29b. Signature and title of certifier					e time, date and pla		e cause(s) and n	nanner as sta	
4	5 ≥ 6 0	Н	Haide San	1 in					2	3/ 16	120	NO
			30. Name and address of person who co	mpleted cause of d	leath (Item :	23a) (Type, P	rint)	5976 Show N	~~~ <u> </u>	2160		
	Sta Registr		31. Date filed (Month, Day, Year) NAR 18 2010	R. Registra	ar's Signa	are do	de)				:	
				-1		· //-						

81

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 **Physician** NOSEPH MARCH 21 10:00 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST. THOMAS MORE NURSING & REHAB PRINCE GEORGE'S HYATTSVILLE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Numbe **Funeral** Hours Days Months 1 XM 2 ☐ F Director 579-70-2277 58 SEPT. 9 1951 WASHINGTON, DC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exprinse must be notified at 1 TyYes 2 □ No Director MD PRINCE GEORGE'S MT. RAINER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 3001 QUEENS CHAPEL ROAD # 202 20712 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ▼No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8TH TRUCK DRIVER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fin and Mental F Be JAMES E. WILLIS **EMMA** WATTS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health an
Important: If item 27 is
any injury or other trau CHRISTOPHER WILLIS/SON 1108 WEST VIEW TERRACE LAUREL, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 3/29/10 LANDOVER, MARYLAND 21. Signature of Funeral Service License J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause a each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ducito (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physician Physician/Medical the aftending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 2 No Ö the is been signed by the should be detached 9 Unknow ۵. 23e. Did tobacco use contribute to the cause of death? ant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 2[™]No 1 ☐ Yes 2 **20**10 1 ☐ Yes within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 WNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title с

AJIT KURUP M.D.

10063681

UNIVERSITY BLVD #208 HYATTSVILLE, MARYLAND

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ ICLI AMIS AMES Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 5805 42nd AVENUE # 419 HYATTSVILLE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** AUG 12 1 M 2 - F Months Days Hours Min T922 SOUTH CAROLINA 87 237-20-0054 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State death with the Maryland at Director 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 ☐ No MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5805 42ND AVENUE # 419 20781 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ^{2 No}ARMY 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Specify: "natural", Completed 3 Divorced 4 Divorced BLACK the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) 12TH life. DO NOT use retired) College (1-4 or 5+) AUTO MECHANIC PRIVATE other Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked ot traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. 2 PURVIS WILLIAMS BERTHA DUBOSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 W STREET S.E. WASHINGTON, DC 20020 DEBORAH GILLIARD/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 3/27/2010 CLINTON , MARYLAND WASHINGTON NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Cervin Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or lingury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Month Pregnant at time of death Yes 2 No as been signed by the 2 should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No certificate 2 🔀 No 1 🗌 Yes 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one Hospital 1 Tyes 2 No 은 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated . Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 Date filed (Month, Day, Year) State MAR 2 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** White March 22,2010 Jeanette Jane /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Wicomico Salisburg Rehabilitations Austra Ctr.
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 20 If Under 24 Hrs. 8. Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Vear) Days Hours 1 □ M 2 🖫 F 62 Months 214-44-1039 Director Maryland 1947 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 No 2 No risfield Director Somer Mary land 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. Somers 21817 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonce. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pecola Wilkens Willis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crisfield 106 St. Sister Locust Cynthia Anderson -20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3127/10 Marion Station, mel 4 Donation 5 Other (Specify) John Wesley U.M.C. Cometery! 21. Signature of Funeral Service Licensee 2. Name and Address of Facility E. Ward Anthony Wand 30639 rincess Anne, md 2,853 Hampden Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): year. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 10 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, certificate has been signed by the rector, page 2 should be detached

After this

ns 23a or 28a-f show must be notified at

3altimore, Maryland 21215-0036

funeral director, Medical Certification: To To the Hospitar constitution 24 hours after death.

To the Funeral Director: After a constitution in the funeral process.

1 ⊟ Yes 2 🖳 🗚 б 27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifies

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Adyorth 3. 2010 7:15 P Braden Brook Altemus Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 4b. City. Town, or Location of Death Examiner Presbyterian Home Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. 7/24/1926 Pennsylvania Director 196-18-4050 83 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10d, Inside City Limits 10c. City. Town or Location Director MD Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 USA 1106 Stevenson Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

XX Yes 2 \(\sum \) No Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: if Yes, Give Year or Dates Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5 Manufacture Rep. Housewares Be 17. Father's Name (First, Middle, Last)
L. Harry Altemus 18. Mother's Name (First, Middle, Maiden Surname) Gladys Grimm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Stevenson Lane Towson,, Maryland 21286 19a. Informant's Name/Relationship (Type, Print) Anne Altemus / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland 4/8/2010 Mary's Govans Towson, Maryland 21204 22. Name and Address of Facility 21. Signature of Funeral Se Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an cate has bage 2 s death? 1 ☐ Yes 2 ☐ No 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 2 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Ycertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number
29d. Date signed (Month, Day, Year)
April 05, 2010

The Print)
Charles Arres, Ballimore Ma 21204 29b. Signature and title of certifier ompleted cause of death (Item 23a) (Type, Print)

Registra

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State

MO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 10595 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year D4AM Ella J. Amberman 2010 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner n/a 5. Social Security Number 7. Age (In yrs. last birthday) Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 8/3/1940 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 69 Director 212-36-9713 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show Director 1 ☐ Yes 2 XNo MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6054 Hunt Club Road 21075 USA by Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Artist 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walton F. Groh Ella J. Noel 2 of Health and Nitem 27 is man 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1137 Ingate Road, Halethorpe, Maryland 21227 Marcus B. Amberman / Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of h
Important; If ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk 4/6/2010 Elkridge, Maryland 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to imm, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) □Yes 2 No 9 Unknown 9 Unkno Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3☐ Probably 4☐ Unknown 1 ☐ Yes 2 ☐ No Completed certificate has been Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No 1 ∐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Tes \$ 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Natural Injury Hospital or Attendi 24 hours after death. Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 0596 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Year Bellamy **Physician** 9:40A M M. OFOTHY 2010 /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns HUS DITAL HOPKINS CIT balhmore 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Year) 1 □ M 2 **M**F Months Days Hours Min 2-28-1939 MD Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1XYes 2 □ No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1612 E. Madison Street 21205 SA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√∑ No Specify. Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Ward Clerk 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Hill Viola Vincent ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 Lisa Bellamy-Smith-daughter 356 Washington Avenue Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4-10-2010 Randallstown, MD King Memorial Pk 21. Signature of Fune Al Service Licensee 22. Name and Address of Facility March East F/H 1101 E.North Avenue Balto, MD 21202 mul 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (vabe Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed n Department of Health and Mental Hygic Important: If item 27 Is marked other I any injury or other traumatic event, III

Funeral

Director

?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Medical Exp. rither must be notified at

death with

72 hours after

Baltimore, Maryland 21215-0036

burial-transi and physician s the burial attending p the ģ signed I been si cate has b page 2 s certificate this certific al director, After thi funeral of

Be

Certification: To

Medical

law requires that the death certificate be executed

or Attending Physician: The

the Hospital

death.

within 24 hours after death
To the Funeral Director:
completely filled in by the

Box 68760,

P.0.

Records,

Division of Vital

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 Natural
2 □ Accident

5 Pending investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

Location (Street and Number or Rural Route Number, City or Town, State)

300t.

29a. Certifier (Check only

3 Suicide

4 Homicide

TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year) 31. Date filed (Month, Day,

Ovleans Street 2323 legistrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:30 A [™] 24 2010 MILDRED BROOKHAR MARCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ellicott City Health & Rehab Ellicott City Howard 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 🔀 F July 20, 1921 Maryland 213-14-9419 88 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Director Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 IISA 303 Maiden Choice Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No altimore, Maryland 21215-0036 Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Judge Relmond VanDaniker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2518 Jonathan Road; Ellicott City, MD 21042 Daughter Judith B. Lomp 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/29/2010 Glen Burnie, MD Atlantic Crematory 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 23a. Partf. Enter the disease, or complications that caused the leath. Dynot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or in one cause on each line. 1630 Edmondson Avenue: Catonsville, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MINUTES **Physician** CARDIAE /Medical Due to (or as a consequence of): Coronary Artery Disease **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. g 1 Tes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this eral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 ☐ Pending investigation within 24 hours after uccar...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD MARCH 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N CHAPLES DUNSMORE BALTIMORE, MD MD

Registrar

State

32. Registrar's gnatu

amend item 17 per fth 902 4-7-10 vt. and Mental Hygiene 2

Amend Item II per spouse G905 727/Mental Hygiene 2

Certificate of Death

Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 3 Day 3 Physician/ 2:40 PM povans nar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex ast birthday) 8. Date of Birth 7. Age (In vrs. **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. Month, Day, 3 9 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 ₩idowed 4 □ Divorced Specify: Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical i 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) lnion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Arnett Bevans 19a. Informant's Name/Relationship (Type, Print) (daughter, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) APT. 1 and 2 sof Health 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 2010 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Joseph tome 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cardiac Arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ulmonary vears Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Physician: The law requires that the death certificate be executed burial-transi nterstitia and that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Physician/Medical Box 68760 the attending posterior that the attending posterior than the attending po IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 | Unknown 9 Unknown P.O. I ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, [1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe certificate | 1 ☐ Yes 2 ☐ No director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending iniury 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) .0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PKWY 201 E Baltimore, universit lalek 31. Date filed (Month, Day, gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend # 10f, 19b, & 20c, per Fil 9902 4/30/10 TT Registrar Registrar Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 3:31 AM April Lawrance Frederick Blucher, Sr. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Baltimore Rosedale Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09/30/1927 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 M 2 □ F Months Days Hours Country) Maryland Director 214-24-2431 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1∩a State 10h County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Director Baltimore MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō U.S.A. items 23a 9420 Twilight Drive 21226 21236 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married blucher, Lawrence Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates: WW II Specify: ð 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic event, Item Maone. Elementary/Secondary (0-12) College (1-4or 5+) filed within I Hygiene. Fire Department Fire Officer 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) be f Mary Catherine Anzengruber Vernon Dallas Blucher Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9420 Twilight Drive - Baltimore, Maryland 21226 Janet E. Blucher (wife) 20c. Location - City or Town, State Perry Hall, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Michael Luth.Cem. 04/08/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sixure of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. Mother 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myocardia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner oronary artery if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner be executed NTH burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial Box 68760 Physician/Medical the death certificate 38 attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Vear Month Day 5 Other (specify) signed by the a Ö 1 □Yes 2 □ No 9 Unknown ۵, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has page 2 2 □No 1 ☐ Yes 1 □ Yes Physician: 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After or Attending 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Jepital c.
4 hours after dec.
- meral Director: After 1 □Yes 2 □No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my online. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/200

Lawrence

square Drive Baltimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

Franklin 32. Registrar's Signature

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Michael Baron 04 04 2010 /Medical 14:40 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Social Security Number 6. Sex 7. Age (In yrs. las Air ear If Under 24 Hrs. 8. Date of Birth (Month, Day, Harford Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Director 07/23/1926 207-16-1395 Pennsylvania Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ? Is marked other than "natural", or Items 23a or 28a-f shot traumatic event, the Modical Experiment must be notified at Director 1 ☐ Yes 21 No MD Baltimore Fork 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6416 Brinton Lane 21051 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW T1 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 2 Specify: 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 12 6 Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If item 27 is marked out any injury or other traumatic even once. Be Paul Baron ျှ Mary (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3914 Donerin Way - Phoenix, Maryland Michael Baron (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John Epis.Ch.Cem. 04/09/2010 Kingsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. E.A assah 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** respira disease or condition resulting in death) DYPOXIC /Medical t (or as a consequence of Examiner Sequentially list conditions, Examine if any loading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): 68760 attending physician Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No the O. 9 Unknown signed by t ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Records, law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The certificate | performed of Vital 1 □Yes 2 No 2 **N**0 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No 1 Inpatient Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

000

- 500 Upper Chesapeake Drive - Bel Air, MD

lannen,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

onea

Sonia Mannen,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice enbrument Hospita Baltimore Kandalistown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Min. Country) MD Director Usual Residence of Decedent or 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoiury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore 1 Yes 2 No andalistown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Lausanne 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates. Specify: Black Specify: Completed 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Dietar Oth Wade NIA Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mollie obert Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Load Randallstown loria White permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Acomotor 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of I Valu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each lips Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of by the attending physician and stached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached to Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s performed 2 No 1 Yes 25. Was case referred to medical 0 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At hor building, etc. (Specify) - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

7 Medical Examiner On the basic of promiseion and/or inventional and the state of promiseion and th Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

nd address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Ρ. Gene Rond M 2010 Medical Apri. 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 1724 Searles Road Baltimore Co. Dunda1k 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, Day, 1 🔀 M 2 🗆 F Months Hours Min. Country) **Director** 216-30-0036 193 West Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dunda1k 1 Yes 2 No 10e. Street and Numbe 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 1724 Searles Road 21222 United States or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 2 XNo Completed by ☐ Yes should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give "natural", Specify. 3 Widowed 4 Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Years Security Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ida Mae Williamson other traumatic Lexton Bond 19a. Informant's Name/Relationship (Type, Printife Companion). Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1724 Searles Road Dundalk, Maryland Ms. Mildred Sobus 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date any injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/6/2010 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 21. Signature uneral Service Lices 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21222 Dundalk, Maryland 23a. Part 1. Enter the complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart file Immediate Cause (Final re. List only one cause on each line. AACHOM Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. Part II. **Qther significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed by the period of the period of the signal of the si 23e. Did tobacco use contribute to the cause of death? þ recuires Records, 2 No 3 Probably 4 honknown 1 Yes Completed should peen 24a. Was an 24b. Were autopsy findings available page 2 s The law has autopsy prior to completion of cause of death? certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify, 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work Division 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co

DHMH 17 Rev 7/2009

State

Registrar

31. Date filled (Month, Day, Year)

APR 0 7 2010

32. Registrar's Signatur

RMAN HUL Rd DOHORE MA 212

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Barnh 2. 10 Run Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Certie mmun. L Baltomer N/A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country)
pril 10.1926 North 1 X M 2 □ F Months Days Hours Min. Director 83 246-20-6035 April Carolina Usual Residence of Decedent 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked ther than "natural", or items 23a or 28a-f sho any injury or rother traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Edgemere 1 ☐ Yes 2 ☒ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7221 Waldman Avenue 21219 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 XYes 2 No
If Yes, Give Black White etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry 12 Years Steelworker Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Addie Fields Hubert Barnhill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7221 Waldman Avenue Edgemere, Maryland 21219 Susan E. Akehurst (Daughter) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 4/6/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
Dundalk, Maryland 21. Signature of Funeral Service Licensee licha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Small disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-transi Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

2x

State Registrar 29a. Certifier

only one) 29b. Signature and title of certifier

Lock

31. Date filed (Month, Day, Year).

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

2010

29c. License numbe

10-02565
Ricky Beitler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

city belief		tificate of Death	Reg. No.	0 1050
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year April 1, 2010	3. Time of Death 1120 hrs
	Aa. Facility Name (if not institution, give street and number) 11 Baltimore Street	4b. City, Town, or Location of Death Hagerstown	Washington	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. late 187–44–9554 1 M 2 F 55	Ast birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	Fore	irthplace (State or ignPennSyl Vania ountry)
faryland 28a-f show any 1 at once. ector		Town or Location Hagenstown 10f. Zip Code	10g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
h the Maryland 3a or 28a-f sh otified at once	11 Baltimore Street	21740	USA	Gritti y :
15-0036 filed within 72 hours after death with the Maryland I Hygiene. dother than "natural", or items 23a or 28a-f she t, the Medical Examiner must be notified at once e Completed by Funeral Director	11. Marital Status 1	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of	White, etc. Specify: Wh work done 16b. Kind of Business	ite indian, Black,
5-0036 led within 72 hour 1/19giene. other than "natu the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret Laborer	Construction	on
O 8 5 4 8 0	Emanuel Beltler	Cather	(First, Middle, Maiden Surname) ine Liddick	
	19a. Informant's Name/Relationship (Type, Print) Peggy Jones / Sister	19b. Mailing Address (Street and Number or I 12 Dayton Boulevard Car	rlisle Pennsylvania 1	7015
Baltimore, MD permit. Pages 1 and 2 shu Department of Health and Important: If item 27 is injury or other traumat	1 Deurint 2 Vi Cromotion 3 Demousi from State C	Place of Disposition (Name of cemetery, rematory or other place) ffman-Roth F.H. & Crem. 04-0	Date 20c. Location - City of Carlisle Per	
Balti permit. Departu Importi injury o	21 Signature of Funeral Service Licenage	22. Name and Address of Facility. Leonard J. Ruck, Inc. 5305 Harford Road Bal	timore Maryland 21214	
Physician /M in I Examiner		Do not enter the mode of dying, such as cardiac or addone) intoxication	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
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nsit Examiner	(Disease or injury that initiated events resulting in death) Last			1
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	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of dea	nancy 2 Fetal death 3 Ectopic pregna	23d. Date of delive	ry Day Year
P.O. B as that the de igned by the de detached i	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
rds, Frequires been sign hould be			24a. Was an 24b. Were a	utopsy findings available completion of cause of
Vital Reco vysician: The law this certificate has director, page 2 s o Be Comp	25. Was case referred to medical examiner? Hospital: Inpatient 2	26.Place of Death (Check ER/Outpatient 3 DOA Other Nursin		
n of Viding Phys After this funeral di	1 Ves 2 No Impater 2 27. Manner of Death 1 Natural 5 Pending (Month, Day,Year)	28b. Time of Injury 28c. Injury at Work? 1 Yes 2 X No	28d. Describe how injury occurred unk	
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director, edical Certification: To Be C	2 Accident Investigation Fd 4/1/10 28e. Place of Injury - At ho determined (Specific resident)	Fd 11:00 atn	28f. Location (Street and Number or R or Town, State) 11 Baltin	ural Route Number, City nore St
To the Hospit within 24 hour To the Funer. completely fill	29a. Certifier (Check only one) 29a Wedical Examiner: On the best of my knowledg	ge, death occurred at the time, date and place, and		
To vivi	29b. Signature and title of certifier TO TO TO TO TO TO TO TO TO T	29c. License number O.C.M.E. OCN	29d Date signed (Md April 2, 2010	onth, Day, Year)
ϕ	30. Name and address of person who completed cause of death (Item Theodore M. King, Jr., MD. Assistant Medical E			
State Registrar		barre		
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			for State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F rtificate of		/lental Hy	giene Reg. No.2	10	10605
	Physici	an	1. Decedent's Name (First, Middle					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi Examir	cal	Alice Constan 4a. Facility Name (If not institution Long Green Ce	, give street and number)	S	4b. City, Town, o	r Location of Death	April	4c. Cour	2010 hty of Death	3:20 A ^M
	Funeral Director		5. Social Security Number 420-20-9812		(In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 09/23/	1924	Coun	lace (State or Foreigr try) abama
	Maryland f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County MD		10c. City, Town or Lo					11	0d. Inside City Limits
	death with the Maryland ems 23a or 28a-f show er must be notified at	Funeral Director	10e. Street and Number 115 East Melr	ose Avenue	Darcino	10f. Zip Code	1212		10g. Citizen d	of What Coun	try?
5-0036	after or ite mine	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 □ No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Spec	ace - Americ lack, White, e	
21	ges 1 and 2 should be filed within 72 hours at of Health and Mental Hygiene. If item 27 is marked other than "natural", or other traumatic event, the Wedfeal Exa	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-4or 5+	(Give	OO NOT use retired	during most of work	ing		Business/Inc	·
and 21	ould be filed w Mental Hygie arked other t atic event, th	Be	17. Father's Name (First, Middle, Angelo Tom Bo	·	l_Tea	ncher	18. Mother's Nam	e (First, Middle Constar	, Maiden Surn	ucatio ^{ame)}	n
Baltimore, Maryland	nd 2 should be alth and Menta 27 is marked on traumatic ev	ဥ	19a. Informant's Name/Relationsh Dessie Bondur	nip (Type. Print)			and Number or Rui	ral Route Numb	er, City or Tow		Code) 21117
more,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 ☐ Removal from State	20b. Place of Dispo cemetery, crea Ardent Gren	sition (Name of matory or other place nation Sem	vice 04/05	Date 5/2010	20c. Location	n - City or To	wn, State
Baltin	permit. Pages Department o Important: If any injury or once.		21. Signature of Funeral Service		2	2. Name and Addre	ss of Facility Arc	lent Cre	t Cremation Services , Ste., N, Hanover, MD 210		
	Physician /Medical Examiner		23a. Part 1. Enter the dise of or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. ATHEN	the death. Do not en		5.00		250000 F	ASL5	Approximate Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
O. Box 6	ath certifi attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 [☐ Ectopic pregnand	у			Date of delive	ery Day Year
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Division of Vital Records,	The law ate has b oage 2 sl	Completed						24a. Was auto perfo 1 ∐Yes	psy ormed?	prior to cor death?	psy findings available mpletion of cause of 2 □ No
Vita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	26. Place of Deat				
on of	ding Afte fune	Medical Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Injury (Month, Day,	nt 2 ☐ ER/Outpatie y 28b. Time o Injury	f 28c. Inju	4 Mursing Ho		idence 6 C		y)
Divisi	or afte in l	Sertifica	3 Suicide 6 Could r 4 Homicide determ		ry - At home, farm, st (Specify)	reet, factory, office			(Street and Nui wn, State)	mber or Rura	il Route Number,
3	the Hospital hin 24 hours a the Funeral mpletely filled	edical (29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the best o Examiner: On the basis of and manner stat	examination and/or in	h occurred at the ti	me, date and place opinion, death occur	, and due to the rred at the time	e cause(s) and , date and plac	manner as se, and due to	stated. the cause(s)
	To the To the Committee of the tension of the tensi	Σ	29b. Signature and title of certifier	wallas	a hard	29c. Licens			29d. Date sig		
	Sta	ato	30. Name and address of person 31. Date filed (Month, Day, Year)	who completed cause of de JAL LA LL ⁵ 32. Registra	rath (Item 23a) (Type, 100) 900 r's Signature	Print) 05 KICO	BLIDE K	D, BAC	Thok	es u	0/0 w) 2(236

State Registrar

DHMH 17 Rev 1/2001

S. Jack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ Helen Anne Booz 2010 2:00 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 234 Cartland Way Forest Hill Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days (Month, Day, Year) March 29 1 □ M 2 XX F 213-26-5934 79 Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Forest Hill 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 234 Cartland Way 21050 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3X Widowed 4 □ Divorced white Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) retail retail representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Conelius Loretta Posial 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Hahn/daughter 234 Cartland Way Forest Hill, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Green Mount Crematory

Apr. 6,2010 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home,
5500 York Rd. Baltimore, MD 21 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 12chadrahun disease or condition Medical resulting in death) Due to (r as a consequence of) Examiner Due to (or as a consequence of): weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events ذع يمتم لإ Due to (or as a consequence of): attending physician and for use as the burial-tran resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) the 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Visculities 24b. Were autopsy findings available prior to completion of cause of Domenton 24a. Was an autopsy performed' death? 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Wind Klu mo 231295 4/6/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jack 5 Tel Kenweed mo 21206 KIUESZ 32. Registrar's

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici /Medic		Federico Cortez		Month March 23	B, 2010 1:45 AM M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
,,		Н	St. Thomas More Nursing Home	Hyattsville		Prince George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 147–68–3455 63 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct 30, 1	9. Birthplace (State or Foreign Country) Nicaragua
	pu ,		Usual Residence of Decedent			
	aryla shov	'n	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	he M	Director	MD Prince George's Hya	ttsville	1740	1 ☐ Yes 2 ∏ No
	a or		4922 LaSalle Road	10f. Zip Code 20782	Tog.	. Citizen of What Country? unk
	ns 23	Funeral			ecify Yes or No-	14. Race - American Indian,
.0	r iter	Fur	1 Never Married 2 Married 1 Yes 2 No	B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
Ē Θ	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, I's. Madical Even instruction citied at	d by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 □ Yes 2 🔯 No Specify:		Specify: hispanic
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121	vithin	Пр	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)		
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Maryland	2 should be filed v and Mental Hygie Is marked other i aumatic event, II	P.	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or Rui	ral Route Number, C	ity or Town, State, Zip Code)
Š	alth a		Victoria Alverez/friend 460	1 Grant Place N.W.	Washingt	on, DC 20016
altimore,	of He of He rothe		20a. Method of Disposition 20b. Place of Dis			c. Location - City or Town, State
Ĕ	Page ment ant: If ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state			
Bail	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic enonce.		Maniel/A, Navlor	22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120	655 W. B	altimore Street
Ą			23a, Part 1, Enter the disease, or complications that caused the death. Do not e		or respiratory arrest,	, Approximate Interval Between
No.	Physician	2 4	shock, or heart failure. List only one or use on each line. Immediate Cause (Final disease or condition	notic CARDIONAS	WAR WA	
	/Medical		resulting in death) Due to (or as a consequence of):	WITC CISIADICALIS	DUTE ADM	36436 9646
	Examiner	L	Sequentially list conditions, b.			
11	ed sit	ine	If any, leading to immediate cause. Enter Underlying Cause, Disease or injury			1
	and and II-tran	Examiner	that initiated events resulting in death) Last C			
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ם מ	ed for	sician/Me	1 Yes 2 No 4 Pregnant at time of death	B∐ Ectopic pregnancy □ Other (s <i>pecify</i>)		Month Day Year
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0	ath. r: Aft	atio	1 Matural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No		
DIVISION	after de la principal de la pr	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death, within 24 hours after death, to the Funeral Director. After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the caus red at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the To the Complete Complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
•			Rullenlevere has	D0001852	1	March 23, 2010
			30. Name and address of person who completed cause of death (Item 23a) (Typ	Print)	012	yattaille Mores
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's gignature APR 0 7 2010	ed company	9 1401 11	yallalle.
	Registra	ar	APRUTZUIU Leken a. gara			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ eresa Uncese 12: 48 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NIA SInai Hospital Baltimore Lity Baltmore If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Hours (Month, Day, Country) SC Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

The marked other than "natural", or items 23a or 28a-f show often tranmatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mills Baltimore 1 🗌 Yes 2 X No 10e, Street and Numbe No. Zip Code 10g. Citizen of What Country? 2111 Funeral Manor INSA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 21215-0036 Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare CNA 12th grade Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) Simpleton Veddie Susie Gerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) + Daren Court Pikesville MD 21208 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State garrison Forest OWINGS Mills, MD 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility C. Greene Funeral SVCS Yaughn Randallstown, MD 21133 23a. Part 1. Ent ctt. disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute choronic disease or condition resulting in death) 3 Medical Due to (or as a consequence of): Examiner inknown mall Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi neu monia mknown been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an After this certificate has autopsy page 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) ပု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending 2 🗌 No Accident Suicide Investigation within 24 hours after death

To the Funeral Director; of completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES -000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) an State Registrar

checse

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Samuel Joseph Collett 2010 5:10 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Golden Living Center 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Wonth, Pay, Year 8 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Country) Maryland **X**M 2□ F 217-05-8301 92 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Westminster Carroll Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21158 207 Bell Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ki Yes 2 I No If Yes, Give WWII Year or Dates: 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Brown Thomas Collett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 207 Bell Rd. Westminster, MD. 21158 Victor DePaola - nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Mem. Gardens April 9,2010 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Finksburg, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Hatt 11605 Reisterstown Rd. Owings Mills, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ongestive checiany opathi 6 mon Kn /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a consequence of) Completed by Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐Live birth 2 Fetal death Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown A MIML FIBRICLANGS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No 1∐ Yes the Hospital or Attending Physician: ' 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Funeral Dir To the Funeral Dir → on filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 31660 6/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WE STMM STER MARYLAND DIST 291 STONEL ACENCE

Registrar DHMH 17 Rev 1/2001

State

Tromas K. Galuwi

31. Date filed (Month, Day, Year) --

ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2010 Mable C. Draughn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parville Balto Genesis Loch Raven 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2 ▼ F 219-22-8967 82 VA Director 5-18-1928 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Md na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 Belvedere Avenue USA Funeral Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry na Elementary/Secondary (0-12) College (1-4or 5+) na 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Coles Francis Edwards ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mae F. Scott Bland-Sister 4348 Robertson Avenue Balto, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Garrison Forest 4-8-2010 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H Lemont on I 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical ası IF FEMALE: f yes, outcome pf pregnancy □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 🗖 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No has e 2 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 □ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and Me of certifie 29c. License number 29d. Date signed (Month, Day, Year) SICICIA

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner dsor . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral M 2 □ F Hours Min. Country) Director 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10e. Street and Numbe ò 10g. Citizen of What Country? Funeral 23a USA items 2 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ✓ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", Year or Dates. 1971 Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DONOT use retired) 15. Decedent's Education (Specify only highest grade completed) 72 1 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked on any injury or other traumatic eve ၉ Informant's Name/Relationship (Type, Plint) Da Baltimore, Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a con a guence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day Ye 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 1 V Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basi of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of ertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Regist State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 2010 ear SHIRLEY MARIE DIFFENBAUGH 2, РМ 4:35 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 7929 BRIDGE AVE. ROSEDALE BALTIMORE | KUD בעראנים | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG • 26 • 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 □ M 2 □ F Yrs 70 1939 216-36-3978 MD. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 TYes 2 No MD. BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 BRIDGE AVE. 21237 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐Yes 2 X No WHITE Specify Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10TH 0 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DOXSEY OWEN MARY OKEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT DIFFENBAUGH/HUSBAND 7920 BRIDGE AVE., BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State OAK LAWN CEMETERY 4/8/2010 BALTIMORE, MARYLAND 4 Donation 5 Dother (Specify) 21. Sign if re of Fun al Service License 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part 1. Enter the disease of complications that caused to shock, or heart failure last only one cause on each line omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Fina relegialic Lance 14eurs disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any list cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐Yes 26. Place of Death (Check only one)

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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23a

death 1 or items

72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

of Vital Records,

Physician:

or Attending Division

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

Director

Funeral

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Completed

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other traumatic event, the Medical Examiner must be notified at

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1 and 2 Health a

> physician and s the burial-tran use as attending p for use as signed by the a has page 2 certificate director, this After

Examiner filled in by the funeral

Physician/Medical ρ Completed Be Certification: To

Medical

State Registrar

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 TYes 2 🗆 No 2 Accident 6 ☐Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

29a. Certifier

ECTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

014714

29d. Date signed (Month, Day, Year)

urled ura; 30. Name and address of person who completed e of death (Item 23a) (Type, Print)

THRUML MI LYARL

and manner stated.

Pegistrar's Signature 31. Date filed (Month, Day, Year) 32.

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April JESSE WARREN ESSLINGER 4^{Pay} 2010^{ear} 11:43A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE TOWSON BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Yea Oct 7, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Min. 213~26~7812 79 Hours Director Oct. Maryland Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Lutherville 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14 Dublin Drive 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ģ Black, White, etc. 1 Never Married 2XX Married X X Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: White If Yes, Give Year or Dates 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 yrs. 1 yr. Business Manager Bendix Corporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jesse Reese Esslinger Bertha Barke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Dublin Drive Lutherville, Md. Sonja Esslinger (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 4~7~2010 Dulaney Valley M. G. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. Signalure of Funeral Service Licensee 22 Name and Address of Facility Lassann Funeral Home 7401 Belair Rd. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Squamous cell conces of Pnysician/ disease or condition resulting in death) Medical Due to b as a consequence of) Examiner Sequentially list conditions, if any, leading to investigate Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or linjury Que to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 L 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗆 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto Md 2(204 BINC 6701

Registrar
DHMH 17 Rev 7/2009

State

filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	tate of Maryland / [rtment of H ificate of D		and Mental		/ 11 1 1	10614
			Registrar 1. Decedent's Name (First, Middle, Last)		Cert	incate of L	Calli	2. Date o	Reg. I	No.	3. Time of Death
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The state of the s	Examir		4a. Facility Name (If not institution, give stree	t and number) •		4b. City, Town, or	Location o			4c. County of Dea	ath
			The Johns Hopkins Hosp 5. Social Security Number 6. Sex		the star of	Baltimore If Under 1 Year	City If Under	24 Hrs. 8. Date o	f Dieth	N/A	rthplace (State of Foreign
	Funeral Director		5. Social Security Number 6. Sex 1XXVIII	2 G F 7. Age (In yrs. last birt	Yrs.	Months Days	Hours	Min. (Month	Day, Yea	7) 1970 PE	NNSLYVANIA
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	arylar show d at	5	10a. State 10b. County	10c. City, Towr							10d. Inside City Limits f X Yes 2 □ No
	the M 28a-f otifie	Director	VIRGINIA 10e. Street and Number		VIRO	GINIA BEA	CH		100.0	Citizen of What C	
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	ems ?	Funeral	11. Marital Status 12.	Vas Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His	spanic Orio	gin? (Specify Yes or Puerto Rican, etc.	No-	14. Race - Am Black, Whi	
36	s after , or it	by Fu	1 Never Married 2XXMarried	X∑Xves 2 □ No f Yes, Give		☐ Yes 2X No	Specify:	, , , , , , , , , , , , , , , , , , , ,			LACK
21215-0036	tural"		15. Decedent's Education	/ear or Dates:		ent's Usual Occupa			16b	. Kind of Business	
212	hin 72 In "na Medic	Completed	(Specify only highest grade co			ind of work done d O NOT use retired)		of working			•
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)					r's Name (First, Mi		,	
ž	2 should to and Menton Is marked raumatic e	오	RENALDO TILLERY 19a. Informant's Name/Relationship (Type. F	Print) 19b	. Mailing	Address (Street a		ATRICIA P er or Rural Route N			Zip Code)
<u>B</u>	nd 2 south and 2 s		Tonya Eikerenkoetter			,		Va.Beach,			
re,	of Hear		20a. Method of Disposition	20b. Place of	f Dispos	ition (Name of atory or other place)	i	Date Deach		Location - City of	
<u>E</u>	Page nent o		1 X Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Dopation 5 ☐ Other (Specify)	vai iroiti otate		Horton (4-07-10	ST	UFFOLK,	VIRGINIA
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licensee		22. W	Name and Addres	s of Facility BROW	N COMMUNI	TY FU	UNERAL H	OME P.A.
	₫ □ = e 0	9	28a, Par 1, Enter the disease, of complication	ns that caused the death. Do r		the mode of dving			rv arrest.		Approximate
	Obveision	Ž 4	28a PM 1. Enter the disease, of complication shock, or heart failure. List only one ca	use on each line.	4	intach		Rlean	1		Interval Between Onset and Death
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89	rtificate ig phy as th	-	IF FEMALE:			-					
Box	The law requires that the death certifics to has been signed by the attending phage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal death		Ectopic pregnancy				23d. Date of de Month	elivery Day Year
	the all	ysic		☐ Pregnant at time of death☐ Unknown	5 🗌	Other (specify)			_		
, P.O	v requires that the de been signed by the a should be detached	by Pl	Part II. Other significant conditions contribu	iting to death but not resulting i	in the ur	derlying cause giv	en in Part	23e. [Did tobacc	o use contribute	to the cause of death?
g	quires n sign	ed k				-		_ _ '	Yes	2 XNo 3 □ P	robably 4 🗌 Unknown
900	ne law requ has been ige 2 shou	Completed						24a. V	utopsy	prior to	utopsy findings available completion of cause of
Vital Records,										? death? No 1 TYe	s 2 🗆 No
	ysician: The L s certificate ha director, page	Be	25. Was case referred to medical examiner?	ital: 1 Inpatient 2 ER/Ou	tnationt	3 DOA Othe		of Death (Check or sing Home 5 - F		6 ☐ Other (Spe	
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Division of	II or Attending Physician: s after death. Director: After this certification by the funeral director,	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Be. Place of injury - At home, far building, etc. (Specify)	rm, stree	et, factory, office			on (Street Town, Sta		Rural Route Number,
	Hospital	O	29a. Certifier 1 Certifying Physicial	n: To the best of my knowledge	, death	occurred at the tim	e, date an	d place, and due to	the cause	e(s) and manner a	as stated.
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	(check only 2 Medical Examiner:	On the basis of examination and manner stated.	d/or inve	estigation, in my op	oinion, dea	th occurred at the t	ime, date	and place, and de	ue to the cause(s)
	To the I within 2 To the I comple	ž	29b. Signature and title of certifier) 🙃 – /	1 .	29c. License			29d. [Date signed (Mon	
			GATHE Defense to	ha De Jesus-F		<u></u>	609	4	Hp	rila	9010
-			30. Name and address of person who compl	eted cause of death (Item 23a) COSTC	(Type, P	rint)		600 North \	Volfe	St. Baltim	ore, MD, 21287
	Sta	te	31. Date filed (Month, Day, Year) APR 0 7 2010		16-	V. J				,	,,,
	Registr	ar	APR 0 7 2010	32. Registrar's Signature	par						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760 o 7 Division of Vital Records,

death. Director: within 24 hours a

To the Funeral D the Hospital

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

title of certifier

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a, Certifier

29b. Signature a

Medical

State Registrar

DHMH 17 Rev 1/2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1)35398

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4/7/10

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year APRIL 12:38 PM Charles J. Franklin, Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER BALTIMORE TOWSON 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🗖 M 2 🖵 F Months Days Hours Min **Director** 212-46-7909 63 Dec Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗋 Yes 2 🙀 No MD Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13912 Manor Road 21131 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black White etc. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 d Mental Hygiene. marked other than "natural", 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Director of Media Relations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Florence Spindler <u>Charles J. Franklin.</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13912 Manor Road; Phoenix, Jane P. Franklin wife MD 21131 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Other (Specify) Hilltop Service Corp. 4/6/2010 Towson. MD 21. Signature of Furieral 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complicat that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one ca Immediate Cause (Final Onset and Death Ph sician/ ASTHMA EXACERBATION disease or condition resulting in death) ACUTE 2 HOURS Medical Due to (or as a consequence of) Examiner CARS CONGESTIVE FAILURE HEART Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed KEACTIVE AIRWAY that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months? Month Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBESIT 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy 1 Yes Be 26. Place of Death (Check only one) Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29d, Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

P. CUNNINGHAM 7601 OSLER DRIVE egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

D0039215

415/2010

TOWSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Physician/ 1 2010 p^{M} 5:40 Michael E. Grant Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Balto Gilchrist Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Days Hours Min. 1 - 1 9 - 1 9 5 3 Director 215-60-5226 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location death with the Maryland "natural", or items 23a or 28a-f sho Director na 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21218 2639 Barclay Street USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working unk and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade years Home Improvement Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is meany injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Grission Nathaniel Grant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leah Mason-Grant-Wife 1310 Windemere Avenue Balto, MD 21281 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
King Memorial Pk 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4-8-2010 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility March East F/H ille W. 1101 E. Balto, MD 21202 North Avenue 23a. Pn. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SOUTHDUS CELL CANCEL OF NASOPHARYNX disease or condition resulting in death) MONTHS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours are death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OHRONIC KLONEN DISEASE Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 A Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: HOSPILE ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred work?
1 Yes 2 No injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifie certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 0.64395 29b. Signature and title of APRIL 1,2010

State Registrar

2

32. Regist ar's Signature

6701 N CHARLES ST. 8WITE 4105 BALTIMENE, MA 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05:15 AM Gudenius Josephine 2010 PRIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SAIN'T JOSEPH MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 💢 F Months Hours 63719/19/1937 MD **Director** 213-34-7385 Usual Residence of Decedent show 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21214 5603 Birchwood Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: "natural" Completed White Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Balto. City Housing Cashier Coordinator 12 Be it. Page 1 and 2 should but. artment of Health and Mental Hy
. If item 27 is marked of " anic eve 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Prosdocini Bosica Rose Carmino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5603 Birchwood Avenue, Baltimore, MD 21214 Joanne G. Evans, Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Parkwood Cemetery 04/09/2010 4 ☐ Donation 5 ☐ Other (Specify) Leonard J. Ruck, Inc. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician END STAGE RENAL DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MELLITUS - TYPE Z DIABETES VEARS Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> VENOUS THROMBOSIS or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 1 Tes peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 No 1 🗌 Yes Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or invastigation. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41104 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 TOWSON MARYLAND 7601 OSLER DRIVE THEODORE C. HOUCK MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 5:20 PM 2010 04 James /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hamilton Nursing Center Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2□ F Maryland 94 215-12-124 -12-1915 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 4 N. Luzerne Avenue Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No White Specify. þ Specify: WII 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Manufacturing Steel Worker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Louise Marriniak John Giza 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5507 Fair Oaks Avenue Baltimore, Maryland 21214 Mr. Paul E. Giza - Son more, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State St. Stanislaus Cemetery 04-08-2010 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signalur of Finery Service Licensee 5305 Harrford Road 22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Infer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) ivision or Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

or Attending

within 24 hours after death To the Funeral Director:

10

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N. Charles Street, Suite 203

32. Registrar's Signature

and manner stated.

Baltimore, Maryland 21204

29b. Signature and title of certifier

29a, Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 230 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE JOHNS HOPKINS BANVIEW MED CENTER N/A Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🏻 F OCT. 29, Months Days Hours Director 1970 MD 219-06-5237 Usual Residence of Decedent show ould be filed within 72 hours after death with the Maryland id Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits N/A BALTIMORE MD. 1yE Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral UNITED STATES 21224 326 ELRINA ST Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GROCERY STORE 0 MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CHARLES GUMP MARGARET AMEND permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET GUMP/MOTHER 628 GRUNDY ST., BALTIMORE, MARYLAND 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 4/6/2010 BALTIMORE, MARYLAND 22. Name and Address of Facility CHARLES S. ZEILER & SON, 21. Signature of Funeral Service Licenses INC. BALTIMORE, MARYLAND 21224 EASTERN AVE. 23a. Part 1. Enter the disease, or conshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, any one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) ARDIAC ARREST Medical Due to (or as a consequence of) Examiner HOURS Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit WEEKS or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury COLITIS that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 9 XUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NON-ALCOHOLIC STEATOHEPATITIS 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar EASTERN

egistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E155

31. Date filed (Month, Day, Year)

RES-000

AVENUE BALTIMORE

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 120 ber 04 Henry 05 2010 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore C Hospital peaalh Miverside N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 **X**M 2 ☐ F Months Hours Florida Director 267-76-2394 73 02/08/1937 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f sh notified 1 Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 7 501 W. Franklin Street 21201 Funeral $U_{\bullet}S_{\bullet}A_{\bullet}$ ural", or items 2 I Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after intent of Health and Mental Hygiene. and the fire and intent of Health and Mental Hygiene. It it item 27 is marked other than "natural", or item any or other traumaft event, the Medical Examiner ury or other traumaft event, the Medical Examiner. 1 ☐ Yes 2 🙀 No If Yes, Give 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed by 3 Widowed 4 Divorced Year or Dates: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Fisherman</u> Self 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk ဥ Unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Blanche Henry(wife) P.O. Box W720, Woods Center, Antigua, W.I. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Joseph Brown F7 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) And Crematory 04/08/10 Baltimore, MD 21. Signature of Funeral Service Licenses Joseph Address of Edition Jr. Funeral Home Miamo 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sersis /Medical Due to (or as a consequence of): Examiner Intestinal Obstruct Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine letastatic attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No whe page 2 autopsy performed' alnutution 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death
1 A Natural
2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day 1 Yes 2 No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month. Dav. Year) MD 2010

State Registrar 31. Date filed (Month, Day, Year) **APR 0 7 2010** 21230

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ DITH LANSON 2010 Medical 4a. Facility Name (if not institution, give street and number b. City, Town, or Location of Death
But TI MONE Examiner 4c. County of Death Medica If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗗 F 240-72-6 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 1 Yes 2 No Specify. Black Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT-use retired)

Tacforey 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Boodwill Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Inice Silver 19a. Informant's Name/Relationship (Type, Print) 6 PMIO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERRAIN North Rose Balto. Md. 21224 lanua Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Owingsmills injury 4 □ Dopertion 5 □ Other (Specify) 21. Sign we of June Service Li any 234. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart facture. List only one cause on each line. Approximate Immediate Cause (Final and Death カンンン Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Unknown Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 🗌 Yes 2. N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ျင Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after occur.

To the Funeral Director. After t Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier

State Registrar JUli

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

BONACUM MU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 6, Physician/ 2010 7:40 A.M Janet Allman Hill Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carroll Westminster Dove House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** (Month, Day Ye 1 □ M 2XXF Months Days Maryland Sep. 1929 80 Yrs. Director 215-28-3378 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2XXNo Carroll Manchester Maryland 10g. Citizen of What Country? United States of America 10e. Street and Number Funeral 21102 4228 Hanover Pike 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes XX No Specify Specify: XXWidowed 4 ☐ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Black and Decker Assembly Line 11th Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be file and Mental F မ Jesse A. Myers Florence Leaf traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a item 27 i Elva J. Alsruhe (Daughter) 4020 Schalk Road, #2, Manchester, Maryland 21102 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 7, ŏ Department of Important: If it any injury or o Crematory 2010 Catonsville, Maryland
22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 4 Donation 5 Other (Specify) Metro Crematory Signature of Fune al Stripe License 3296 Charmil Drive, Manchester, Maryland 21102 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause of each like.

Le Cause (Final accordition) nterval Between Onset and Death diate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 1 Yes 2 No 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be NOVE LOUR Hospital Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Investigation Accident completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23 Crossygads Dr. Ste 340 Dwings Mills, MD 21117 Flavio Kruter MD 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /	Depa	rtment of He	alth and M	lental Hyg	jiene				
			State Registrar	Cen	tificate of De	ath	F	Reg. No. 20101624				
Phys	iciar	1/	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month April 1 2010			3. Time of Death		
. Mo	edic	al .	Muriel Catherin	ie Ha			April			8:52P M		
Exa	mine	er	4a. Facility Name (if not institution, give street and number) National Lutheran Home		4b. City, Town, or Lo	ville		4c. County of Death				
Fune	rai		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthdav)		VIIIE Under 24 Hrs.	8. Date of Birth		1gome1	olace (State or Foreign		
Direc	_		217-18-6430 1 M 2X F 91	Yrs.	Months Days H	Hours Min.	(Month, Day,		Coun			
			Usual Residence of Decedent				OCPC I	011710				
yland if sho	a l	ito	10a. State 10b. County 10c. City, Tow	vn or Loc	ation				1	0d. Inside City Limits		
Mar 28a		įį	MD N/A	F	altimore (City				1 X Yes 2 □ No		
th the	2	la L	10e. Street and Number		10f. Zip Code			10g. Citizen of				
ath wi		Funeral Director	332 South Robinson Street 11. Marital Status 12. Was Decedent Ever in U.S.	13 M	2122 /as Decedent of Hispa		cify Ves or No-	United	Stat			
er de or ite		P. F	1 XNever Married 2 Married 1 Yes 2 No	lf.	Yes, specify Cuban, N	Mexican, Puerto I	Rican, etc.)		ck, White,			
Z15-UU36 in 72 hours after e. nan "natural", o Medical Exam	LVG	g	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🔀 No S	Specify:		Specify	· .	White		
5-U hour first		Completed	15. Decedent's Education 16a (Specify only highest grade completed)	a. Deced	ent's Usual Occupation	on na mast of worki	ng .	16b. Kind of B	lusiness Inc	dustry		
Lin 72		Ē	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DC	NOT use retired)	ng most of worki	'g					
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d Me			Joseph John Hammer 19a. Informant's Name/Relationship (Type, Print) 19	0 14 195 1					D4-4- 7:- (20 40)		
Mar 2 shou Ith and 27 is m	8		Myrtle C. Lobig (Cousin)		g Address (Street and 48th Stree			-				
and Head		ŀ	20a. Method of Disposition 20b. Place	of Dispos	sition (Name of		Date	20c. Location				
age lent of			122 Dallas 2 - Cleritation 5 - Heritoval non State	•	atory or other place) Cemetery	4/5/	2010	Raltin	nore	Maryland		
Baltimore, IMaryland 21213-UU36 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any inition or other trainmafts event, the Medical Examinar must be notified at	ej l	1	21. Signature of Funeral Service Licensee			of Facility	2010	Darein	10105	TRITY TRITE		
	once		Vesta Conce	1 7	Name and Address of Uda-Ruck 1 922 Wise A	Funeral Ave. Du	Home or ndalk,	Dundal Marylan	d 21	1c. 222		
			23a Part 1. Enter the disease or complications that caused the death. Do shock, or heart failure List only one cause on each line.							Approximate Interval Between		
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Medie Examir	_		resulting in death) Due to (or as a consequence of):									
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and and -tran		Exal	that infliated events resulting in death) Last Due to (or as a consequence	of):		<u>-</u> <u>-</u>			_			
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icate b		an r	d									
certifica moding p		by Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	# 0 F	Fata-ia-a-a-a-a-a-a-a-a-a-a-a-a-a-a-a-a-a			23d. Da	ate of delive	ery		
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Physi Physi this c		<u>٩</u>	1 Yes 2 LX No 1 Inpatient 2 ER/C	Outpatien Time of		4 Nursing Ho		_		2		
ding h. After funer		Certificate:	1 M Natural 5 ☐ Pending (Month, Day, Year)	injury	28c. Injury at work? M1 □ Yes	s 2 🗆 No	28d. Describe h	ow injury occur	red			
SIO Atten deat ctor:		Ĕ∣	2 ☐ Accident Investigation 3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury. At home, f	arm, stre			28f. Location (S	treet and Numb	per or Rura	I Route Number.		
UNISION OT VITAL RECORDS, cal or Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be a clin by the funeral director, page 2 should be			4 ☐ Homicide determined building, etc. (Specify)		, , ,		City or Tow	(Street and Number or Rural Route Number, own, State)				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the purial-transic completed filled in by the funeral director, page 2 should be detached for use as the purial-transic		Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge	, death o	ccured at the time, da	ate and place, an	d due to the cau	use(s) and man	ner as state	ed.		
the Hain 24 the Fu		Me	(Check 2 ☐ Medical Examiner: On the basis of examination and only one) 3 ☐ Certifying Nurse Practioner: To the best of my known that the basis of examination and only one.									
Tot with			29b. Signature and title of certifier		29c. License nu			29d. Date signe	~	_		
			Jam & Malle MD		1000	5061.	2	April	21	2010		
_ ک			30. Name and address of person who completed cause of death (Item 23a)	(Type, P	Doos	2000	50					
	State		31. Date filed (Month, Day, Year) 32. Registrar's Strature	1110	1 jona	201.						
Regi			100 07 2010 Beach B. A.	BIRE								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AFRIDay Paul Edwards Harper 8:05F Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death Saint Joseph Medical Center Towson Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days Hours Min. Director 213-50-3884 59 1950 Maryland June Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md. Baltimore Timonium 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Sawgrass Court 21093 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔀 No Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 X Divorced Specify: White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Chief Financial Officer Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Alva Harper Cornelia Esther Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allison L. Harper/ Daughter 5 Sawgrass Court Timonium, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Hilltop Service Co. 4-9-10 Towson, Md. 22. Name and Address of Facility on Funeral Home, 1050 York Rd. Towson, Md. Signature of Fuperal Service Licenses 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ATHEROSCLEROSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? certificate 1 X Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) 2X No Other: မှ 1 Yes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at After 28d. Describe how injury occurred n 24 hours after death. e Funeral Director: After pleted filled in by the fun 1 Natural 5 Pending injury 1 Yes Investigation 6 Could not be 2 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Nov. A. Branker, M. ?

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DHMH 17 Rev 7/2009

State

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

M.

32. Degistrar's Signature

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TOWSON,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Toccora Isaac	R	- For State legistrar			f Maryla			nent of cate of			d Men	tal Hy		Reg. No	20	10	10626
Physician Medical Examine	ŗ	1. Decedent's Name		,	Shai	ntel	l		Isa	ac			2. Date of De Month April 5, 2	Day	Year		3. Time of Death 0920 hrs
	4	4a. Facility Name (i Johns Hopk	f not institution		treet and nu	ımber)	_	4	•	Town, or more	Location of	of Death		4	c. County of	Death	
Funeral Director		5. Social Security N		6. Sex	1 2 X F	7. Age (In	yrs. last b		Mont	der 1 Year ths Days		er 24Hrs. Min.	8. Date of B		WDD/YYYY)		nplace (State or Foreign ntry) MD
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Maryland 28a-f show datonce	2	MD 10e. Street and Nur	N/A mber				_	Ва		more p Code	<u> </u>	·	· T	10g. Ci	itizen of Wha	t Coun	1 X Yes 2 No
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland more of Heath and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be potified at once. To Be Completed by Funeral Director		218 N . I 11. Marital Status 1 Never Marrie 3 Widowed	ed 2 M	arried	AVE . 12. Was Dec Armed Fo	orces?		If Ye	es, spec	lent of His	, Mexican	, Puerto R	cify Yes or N lican, etc.)		J.S.A 14. Race - White, Specify:	Americ etc.	an Indian, Black,
5-0036 od within 72 hours afte tygiene. other than "natural", the Medical Examiner. Completed by		15. Decedent's Ed Elementary/Second 10th Gr	ondary (0-12)		highest grad		ed) 16a			orking life.					Kind of Busi	ness/In	dustry
Baltimore, MD 21215-0036 cernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other traumatic event, the Medica To Be Comple	8	7. Father's Name (Alonzo 19a. Informant's Na	First, Middle	saa	ac Jr	•	- (1			1	Mon	iane	First, Middle,	tsc		Ctata	7:- O-d-)
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Baltimore, MD 21215. permit. Pages I and 2 should be filled perment of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, the		1 Burial 2 5 4 Donation 5	Cremation Other Si	3 ecify:	Removal fr	om State	Jős	of Disposi atory of oth EPN Crem	Bro ato	wn F ry	'/н	04/	Date 12/10	Ba	Location - 0	ore	. MD
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Division o spiral or Attending nours after death. neral Director: After filled in by the fune Certification:		2 Accident 3 Suicide 4 Homicide	6 Coul	tigation d not be mined	28e. Place (Specify)	e of Injury -	At home,	farm, stree	t, factor	y, office bu	uilding, et	c. 2	8f. Location or Town,		and Number	or Rura	al Route Number, City
To the Hospital within 24 hours a To the Funeral completely filled			Certifying P Medical Exa	niner: O		of examinat											
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State Registra	~	1. Date filed (Monti		h	32. Re	egistrar's Si	gnature	Ked									

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2010 Physician/ April David Carl Johnson 1 5:00 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13378 Grinstead Court Sykesville Howard Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Oct 7, 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign 212-44-9265 Mary land 65 Director Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matting at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13378 Grinstead Court 21784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Builder Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, မ Carl Johnson Eleanor Loizeaux 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol L. Johnson -wife 13378 Grinstead Ct., Sykesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge 4/6/10 Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 William G. Dau 1050 York Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MUDTILOPHIC disease or condition resulting in death) YCAD Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): anding physician and use as the burial-transit death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? io me runeral Director: After this certificate has been signed completed filled in by the funeral director, page 2 should be de þ The law requires 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 🔲 Yes 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending injury Natural N Accident
Suicide 2 \square No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V M6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

P.O. Box 68760

Records,

Division of Vital

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 6:50 PM 31 2010 Woodward Keeney March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Cockeysville
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Maryland Masonic Home Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 09/16/1943 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 3 M 2 □ F 66 Director 215-42-8071 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 3219 Canterbury Lane 21047 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Concrete Manufacturing Vice President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Keeney, Frank Woodward Jr. Bertha Mueller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health item 27 i 3219 Canterbury Lane, Fallston, MD 21047 Mary F. Bacon / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 □ Burial 2 □ Cremation 3 □ Removal from State * 4 ☑Donation 5 ☐ Other (\$pecify) Anatomy Gifts Registry 04/05/2010 Hanover, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Anatomy Gifts Registry icensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition **Physician** eeus /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. δ COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 7 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 27. Manner of Death 28b. Time of 28c. Injury at After t the Hospital or Attending I 1 ⊠Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attene within 24 hours after deatl To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAMB ST BALTO, MM 2 1224 LIBERTOI 3,08 31. Date filed (Month, Day, Year) 32. Registrad's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kem Month Year 245 P M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Director 577-52-1522 Virginia Usual Residence of Decedent 28a-f shov 10a. State Director 10c. City. Town or Location 10d. Inside City Limits notified MD Anne Arundel Harwood 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? 9 pe Funeral "natural", or items 23a odical Examiner must b 1511 C Carmody Court 20776 U.S.A. and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates er than "natur , the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Drug Store Manager Retail Health and Mental Hygie tem 27 is marked other to ther the traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Byrd Moore Ellen Ruthrough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1511 C Carmody Court, Harwood, MD 20776 Vickie Frye / Daughter item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1.
Department of Important: If it any injury or or once. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 04/05/2010 Anatomy Gifts Registry Hanover, Maryland 21. Signature Funeral Sovice licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive, Ste. P, Hanover, MD 21076 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition 460.13 resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown Month Day Year Other (specify) signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has l page 2 s autopsy performe certificate Yes 25. Was case referred to medical examiner? Hospital or Attending Physician: **Division of Vital** funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injurv 5 Pending after death. 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person what

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Knapp		State of Maryland / Department of Certificate of			leg. No. 20	0 1063
Physici Medical Exami				2. Date of Dea Month	Day Year	3. Time of Death 0934 hrs
		THOMSE CAMALA Mapp, DI.	b. City, Town, or Location of De	April 1, 20	4c. County of [
*		St. Agnes Hospital	Baltimore			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 219-76-4635 1X M 2 F 49 Yrs.	If Under 1 Year If Under 24 Months Days Hours M	Hrs. 8. Date of Bi	1-	B. Birthplace (State or Foreign Country) Mary Land
Áu		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
Maryland 28a-f show any d at once.	'n	MD Baltimore				1 X Yes 2 No
Maryla 28a-f	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What	Country?
ith the 23a or notifi		2632 Maemple Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21223	10. 11	U.S.A	
er death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral		s Decedent of Hispanic Origin? (es, specify Cuban, Mexican, Pue		14. Race - A White, e	American Indian, Black, etc.
after or	by F	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:		Specify:	White
2 hours			's Usual Occupation (Give kind out of working life. DO NOT use in		16b. Kind of Busin	ess/Industry
036 ithin 7 re. r than	Completed	12 Disal	oled		N/A	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last)		me (First, Middle, I		
212 Auld be Menta marke c even	To Be	George Chester Knapp, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number of	gy Lee Ch or Rural Route Nun		State. Zip Code)
imore, MD 2 Pages 1 and 2 shou ment of Health and P sant: If item 27 is r or other traumarite		Barbara Deitz 2632	Maemmple Lane,			21223
ore, es l an of Hea If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other	ion (Name of cemetery, er place)	Date	20c. Location - Cit	
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify: Ardent Crema 21. Signature of Fundral Service Licensee 22. Na				MD 21067
Ba Perm Depa Impo	H		ame and Address of Facility Ar 22 Connelley Dr			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.				Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardi	ovascular dise	ase		Death
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate Due to (or as a consequence of):				
sit sd	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
50, te be executed ysician and burial - transit	edical	X UNPENDED AMENDED				
760, cate be physici he buri	Med	IF FEMALE: 23a, 27, permE, g902 23c. If yes, outcome of pregnancy	4/27/10 TT		23d. Date of deli	ivery
Box 6876: death certificate the attending phydd for use as the	cian/	past 12 months?	Il death 3 Ectopic preg	nancy	Month	Day Year
Box 6876(ne death certificate r the attending physeled for use as the b	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	er (Specify)			
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Recor The law 1 icate has t	ompleted		-	_ autops perform 1 ✓ Yes 2	med? deat	
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be	9	25. Was case referred to medical	26.Place of Death (Chec		No 1	Yes 2 No
f Vit Physica or this c	밁	examiner? Hospital: 1 Inpatient 2 FR/Outpatient				ther:
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ivision	Certificati	2 Accident Investigation 28e. Place of Injury - At home, farm, street,				Rural Route Number, City
Di spital	er S	4 Homicide determined (Specify)		or Town, St		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil.	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
L'alla	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
B. (H)		U-MU-m	O.C.M.E.		April 2, 2010	
Of to		 Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 F 	Penn Street, Baltimore, I	MD 21201		
Sta	ate	31. Date filed (Month, Day, Year) APR 0 6 2010 32. Registrar's Signature	7			
Registr DHMH 17 Rev 1/20						
OCME 2006		OCME ORIGINAL				

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert Howard Law 03 10 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Citv. Town, or Location of Death 4c. County of Death **Examiner** Manor Care Rossville Baltimore Rossville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 1 X M 2 □ F **Director** 216-28-0644 79 Dec. 24,1930 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 □Yes 2 □tNo MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 7399 Edsworth Road 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 o. 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If item 27 is marked other that any Injury or other traumatic event, IPs. ODG. 12 Years Years Accounting Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Law 2 Mildred Norris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary E. Law (Wife) 7399 Edsworth Road Dundalk, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Stanislaus Cem. 4/3/2010 Donation 5 Other (Specify) Baltimore, Maryland 21. Signatur of Funeral Service Licensee Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part v Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio nulmonary **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed siclan and burial-trans Due to (or as a consequence of) Physician/Medical as the t use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Vear 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. ned by the a 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal To the I within 2 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 69540 2010. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State

Walnan

APR 0 7 2010

31. Date filed (Month, Day, Year)

swite 204 Parkville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05 04 Rebecca <u>Mitchell</u> 2010 8:20A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Fairfield Nursing Rehab Arundel Crownsville Anne Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 💢 Months Hours Min. 12/03/ N. Carolina Director 92 **1**917 225-16-9799 Usual Residence of Decedent 28a-f shov 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7510 Gleneagle Drive 20794 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Grade Folder <u>Cleaners</u> 1 and 2 should be filed with Health and Mental Hyginitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Unk Sam Terry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerard McLean(Grandson) Canonball Way, Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Nat'L 04/14/10 | Baltimore, MD Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral HOme 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 9 Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical B B 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title on who completed cause of death (Item 23a) (Type, Print) Highway Sw alen Burne

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITM# 10e, 19b, perFH, G902, 4//2010, WS

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April ^{Day} 2010 Year Physician/ Floyd Theodore Misner 5 9:35A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 109 Shaffer Ave. Westmin<u>ster</u> Carroll If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral M D Country) 1 XM 2 F Days Hours Min. 218-40-3679 67 Director Usual Residence of Decedent show 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Carroll Westminster MD 28a-f 1 Yes 2 XNo 10e. Street and Number Shaeffer 10f. Zip Code þ 10g. Citizen of What Country? r than "natural", or items 23a of the Medical Examiner must be Funeral 21157 with 109 Ave. USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces? 1 Yes 2 No Black. White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give þ permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Building 12 Construction event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Albert Misner Pearl Brice or other traumatic and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Harmo Verty Numpa City 7 1941 State, Zip Code) 97 Fox Run Rd., Westminster, MD 21157 item 27 i Bobbi Jo Tawney-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Crem. Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/6/2010 Sykesville, MD Signature Juneral Service Livensee 22. Name and Address of Facility Fletcher Funeral Home Main St., Westminster, MD 21157 Ε. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and I be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes icate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes 2 No 1 ☐ Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 Tes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 1 ☑ Certifying Physician: To est of y kn ge, dea occur2 ☐ Medical Examiner: O e basis of ex ation and/or inventions
3 ☐ Certifying Nurse Pycictioner: To thypest of my knowled the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier , in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 [] 3 [] occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed caush of thath (Item 23 / (Tyre, Print) 31. Date filed (Month, Day, Year) APR 0 7 2010 32. Registrar's State

Registrar

Please Type or Printing Black indelible links, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 9 400 PM ROXANNE DENISE MCDOWELL 03 30 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore Date of Birth (Month, Day, Year)
12-29-1963 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ 212-76-5882 MD Director 46 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 ☐ No Baltimore **Funeral Director** MD na 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 21212 S A 842 Glenwood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2**X**□No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired).

FOOD SERVICES
DISCOLUTED LEGS 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 27 is marked other than "1" traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Geraldine Viney Robert Lewis Pate ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Anthony McDowell-Son Balto, MD 21212 842 Glenwood Avenue item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 4-5-2010 Balto, MD 4 Donation March East F/H 22. Name and Address of Facility Signature of Funeral Service Licensee Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that crossed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Failure Respiratory disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner neumonia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Mediastinal Carcinoma burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 5 ☐ Other (specify) ned by the a 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2, No certificate Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After t 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral C Medical 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within . To the h and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESIDENT naudhar RES 000 PHYSICIAN 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Boulevard, Baltimore Maryland 21239 CHAUD HART SAMEER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Joseph McIntee James 2:50 P 2010 April 1, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Co. Cockeysville Maryland Masonic Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☑ M 2 ☐ F 91 Director Oct. 16,1918 Pennsylvania 212-01-4635 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show witeal Examiner must be notified at 1 □Yes 2√T No Director Middletown New Castle 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 19709 United States 144 Asbury Loop by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ★ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify 3 Widowed 4 Divorced Year or Dates: White WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Martin Marietta 2 Years Purchasing Manager 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Clinton Patrick McIntee ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19709 144 Asbury Loop Middletown, DE David McIntee Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Dulaney Valley Mem. Gdns. 4/7/2010 5 Ther (Specify) Timonium, MD 4 ☐ Donation 22. Name and Address of Facility al Service 21. Signature of Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stane Physician End Medical/الم Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Unwright g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the a should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes ②【No 24a. Was an OSter musico s certificate has b autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending (Month, Day Year) 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Registrar

29b. Signature and title of certific

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

3508

29c. License number

Back St Bulu, Mil 21224

29d. Date signed (Month, Day, Year)

and manner stated.

Mo.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Elmer McDevitt 2:25 AM Physician Ray 2010 /Medical 4c. Coupty of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Torn, or Location of Death Examiner OF ICA MJ W) 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) Sept. 20, 1934 Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days Months 1 M M 2 □ F Yrs 75 218-30-4389 **Director** Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10h. County 10c. City, Town or Location 10a. State 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 TXNo Director Belcamp Harford MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 21017 United States 1123 Belcamp Garth items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 ☑ No Specify þ Specify: White 3€ Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Stationary Company Clerk 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genevieve Heesh William McDevitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Fdgewood Maryland 21040-2823 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. Ms. Shirley Lose(Sister In Law) 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 4/3/2010 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 25 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 sl autopsy performe 1 ☐ Yes 2 ☑ No 1 Tyes 2 No this certific al director, 25. Was case referred medical examiner? 26. Place Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

3 State Registrar

31. Date filed (Mor

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 🥎 3. Time of De 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ GLENN SCOTT MOORE 11:20 AM 2010 PRII Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A 4b. City, Town, or Location of Death Examiner BALTIMORE SINAI HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year, 1 ★ M 2 □ F 56 Director 214-46-9952 WLY 16.1953 Usual Residence of Decedent fshow UNKNOWN UNKNOWN 10a. State 10b. County 10c. City, Town or Location nside City Limits filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director MD 1 Yes 2 No 10e. Street and Number UNKNOWN 10f. Zip Code UNKNOWN 10g. Citizen of What Country? Funeral USA ural", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Who If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc.
WHITE
Specify: þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural", 3 Divorced Completed Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNKNOWN Elementary/Seconday (0-12) College (1-4 or 5+) UNKNOWN Be UNKNOWN UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21202 10 N. CALVERT ST TERRY SHLLIVAN-PERSONAL REP 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State GARDENS OF FAITH 4/7/10 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC ure of Furteral Servise Licensee Sign 6415 BELAIR RD BALTIMORE, MD 21206 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Medical resulting in death) Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year Dav 2 No signed by the a g 🗌 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Records, Completed page 2 should been 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural

Hospital or Attending Physician: funeral director, of Vital To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral Division

2 Accident
3 Suicide
4 Homicide

28c. Injury at work? (Month, Day, Year)

5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🖂 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

death (Item 23a) (Type, Print)

Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Tyrone Murray /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner n/a Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min 165-36-9055 62 8/9/1947 Director New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examinar is ust be notified at 1 ☐ Yes 2 No Director MD Baltimore Halethorpe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3310 Benson Avenue, Apt. G24 21227 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Janitor Cleaning Service permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiry or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dalton Murray Alice Frison ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raquel Murray / Wife 3310 Benson Avenue, Apt. G24, Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) Trinity Cemetery 4/8/2010 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service License 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** otherosile /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dust to (or sels nonsequence of) burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☑ No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 LANo certificate Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 24 hours after death.

Funeral Director: After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the (29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year) 29c. License number 010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0639 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician OTIS S. NELSON April 2010 11:30a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1718 N, LONGWOOD STREET BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 218-42-7936 66 **Director** 28 1944 FEB. SOUTH CAROLINA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1XXYes 2 □ No MARYLAND BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1718 N. LONGWOOD ST. 21216 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2XXVo Specify Specify: BLACK δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event. It is once. 11th grade MACHINE OPERATOR UNILEVE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å ပ္ WILLIE NELSON REBECCA HICKMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Bartee/Daughter <u>2301 Windsor Avenue, Baltimore, Maryland 21216</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 04-10-10 BALTIMORE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part 1. Enter the disease, or shock, or heart failure. List mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ~ hysician disease or condition resulting in death) /Medical of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed pnysician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Path 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: / investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26748 Name and address of person who completed cause of death (Item 23a) (Type, Print)

WIL UBERER 4419FALLS PD BALTOMD21211 31. Date filed (Month, Day, Year) State APR 0 7 2010

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 1 0 1 0 6										
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Dea	Reg. No. 2. Date of Death			10040			
	Physicia Medio			ouis	Nelson		Month April	Day	Year 010	3. Time of Death 7:50 A ^M		
·- 4	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loca	ation of Death		4c. County	of Death			
			2312 Searles Road		Dund				imore			
П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 対 2 □ F 7	birthday) Yrs.		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day Oct. 17		9. Birthp	place (State or Foreign try) ry Land		
			Usual Residence of Decedent			<u> </u>	000. 17	,2002	TIKA	Tyland		
	land f sho	ģ		Town or Loc		1 11			1	0d. Inside City Limits		
	Man 28a- otifie	Director	MD Baltimore			ndalk				1 ☐ Yes 2XXXNo		
	ith the 3a or 1 be r	ral	10e. Street and Number 2312 Searles Road		10f. Zip Code	0	1	Og. Citizen of V		-		
	ath w	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13 V	Vas Decedent of Hispani		cify Yes or No-	Unite	e - Americ			
ဖွ	or ite	by F	Armed Forces? 1 🛣 Never Married 2 🗆 Married 1 🗀 Yes 2 🛣 No		Vas Decedent of Hispani f Yes, specify Cuban, Me		Rican, etc.)		k, White,			
93	ırsaft ural", IExa	ed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 TXNo Sp	ecify:		Specify:	1	White		
5-("2 hou "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupation kind of work done during		ng	16b. Kind of Bu	ısin e ss Inc	dustry		
7	ithin ithen ither	Son	Elementary/Seconday (0-12) College (1-4 or 5+)		O NOT use retired)			D				
0	led w Hygi other ent, t	Be	1 Year 17. Father's Name (First, Middle, Last)	Stu	dent 18.1	Mother's Name	(First, Middle, N	Depen				
Baltimore, Maryland 21215-0036	d be fi Vental arked atic ev	မ	John Andrew Nelson			Gv	ven Rene	e Nelso	n			
lan	shoul and I is ma auma		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and N							
رة ح	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		Mr. & Mrs. John Nelson (Parents)		312 Searles	T				21222		
JOLE			1 🖾 Burial 2 🗌 Cremation 3 🗋 Removal from State cerr	netery, cren	sition (Name of natory or other place)	1	. 1	20c. Location -	-			
Ē	nit. Pa artme ortani injury		4 Donation 5 Other (Specify) Holl:		1 Mem. Gdns			Middle				
Ba	permii Depar Impor any in		De Gorden	D	Name and Address of Fu uda-Ruck Fu 7922 Wise A	ineral H	Home of	Dundalk Marylan	In d 21	C.		
			23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.							Approximate Interval Between		
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	Medical Examiner		resulting in death) Due to (or as a consequent							21/2 11/5		
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ما	ansit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.									
16	execu an an rial-tra	Ĕ	resulting in death) Last Due to (or as a consequence of):									
9	death certificate be executed re attending physician and ed for use as the burial-transit	dical	d						_			
687	ertific ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnance	v				00 D				
Box 687	atten atten for us	ciar	23b. Was decedent pregnant in the past 12 months? 1	eath 3 🗌	Ectopic pregnancy Other (specify)			23d. Dat Moi	e of delive nth	Pry Day Year		
). B	the de	Physician/Me	9 Unknown 9 Unknown									
P.O.	res that the death certifica signed by the attending pl d be detached for use as t		Part II. Other significant conditions contributing to death but not resulti	ing in the u	nderlying cause given in	Part I.	23e. Did tob	*	bute to the	e cause of death?		
rds,	require been si should b	eted					1 □ Y∈	es 2 No	3 ∐ Prob	ably 4 Unknown		
000	has b	Completed by					24a. Was ar autops perforn	y p	Vere autop rior to cor leath?	ssy findings available npletion of cause of		
Ä	sician: The certificate rector, pag		25. Was case referred to medical		00.0	1D 11 (0) 1	1 □ Yes 2		Yes	2 🗆 No		
/ita	sicial certi irecto	o Be	examiner? Hospital:	VO 1 11	_ Other:	f Death (Check	-/					
of \	g Phys er this neral di	te: To	27. Manger of Death 28a. Date of Injury 28	b. Time of	28c. Injury at		ne 5 Reside 8d. Describe ho					
on	endin eath. or: Aft he fur	fical	2 Accident Investigation	ìnjury	M 1 ☐ Yes	2 🗆 No						
Division of Vital Records,	l or Attending lafter death. Director: Affer in by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office	2	28f. Location (Str City or Town		r or Rural	Route Number,		
	spital		29a. Certifier 1 Certifying Physician: To the best of my knowled	ge, death o	ccured at the time, date	and place, and	due to the caus	se(s) and manne	r as stated			
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medical Examiner: On the basis of examination at only one) 3 Certifying Nurse Practioner: To the best of my kr	nd/or invest	igation, in my opinion, dea	ath occurred at	the time, date and	d place, and due	to the cau	se(s) and manner stated.		
	Vithi To th	_	29b. Signature and title of certifier		29c. License num		29	9d. Date signed	(Month, E	Day, Year)		
	h		XWIM		11113	6971	7	4 5	10			
	5		30. Name and address of person who completed cause of death (Item 23	Ba) (Type, P	th breene	ST 2	cotion	ore. N	W	21201		
	Stat	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	hall	J. C. C. C. C.	-1 3	will in	-1-1		-1001		
	Registra		APR 0 7 2010 Course B. M	- Constant								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 27 Helene Siliki Ngeng 2010 3:55a Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery **Examiner** 4b. City, Town, or Location of Death Rockville Casey House If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours 220-75-4892 Director 47 Cameroon Usual Residence of Decedent shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a 11700 Old Columbia Pike #2104 20904 Cameroon 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care 12 Nurse assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Soue Eugene Essoua Ngeng 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11700 Old Columbia Pike #2104 Silver S
Md_20904 19a. Informant's Name/Relationship (Type, Print) Spring Laurent Eugene Ngeng/Son : If item 2 or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or oth 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/21/2010 Souza, Cameroon Family Cemetery 5 Other (Specify) PHIMOLOUAD PRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Year Yes 2 No 1 Yes 2 g Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 N 2 🗌 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🎛 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 🛭 Other (Specify) hospice Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar DHMH 17 Rev 7/2009 32. gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bindu Joseph M.D.

29c. License number D60634

6001 Muncaster Mill Rd. Rockville, Md 20855

Feb. 27, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Owens. Month **Physician** Dosolh 2010 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Overlea Health & Rehab Baltimore Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year' | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M X X F Months Days Hours Min 215-24-9422 80 Director June 20,1929 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland 1 Yes 2 No Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6215 Carter Avenue 21214 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
sint: If item 27 is marked other than "natural", or items 23, and it if item 2 is not other traumatic event, it is not other traumatic event, it is not other traumatic. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify White XX Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10 yrs. Secretary Law Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Michael Michmo Tillie Kluga 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen O. Powell (Daughter) 3741 Seneca Garden Rd. Baltimore, Md. 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4-7-2010 Baltimore, Md. 21. Stanature of Funeral Service Licensee දිදුම්පුදු 7401 Belair Rd. Baltimore, Md. 21236 2 to 2 the 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ther /Medical Due to (or as a consequance of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of) Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚺 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ANo 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 XN0 Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending investigation nours after death.

neral Director: A
filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, To the Hospital o within 24 hours af To the Funeral D' completely filled in

burial-tra

ed by the attending physician detached for use as the buria

has been

certificate

this

death.

director,

with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

10 items 23a

State Registrar

Medical

29b. Signature and title of certifier

29a. Certifier

(Check only one)

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month 4- 2 Day 2010 Physician/ 5:000 M E5516 CC Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death limore 4venue noton 8. Date of Birth Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 1 🗆 M 2 🗷 Yrs. Director Isual Residence of Decedent 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Himore 1 Yes 2 No 10e, Street and Number 10g. Citizen of What Country? Funeral 01244 USA ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 ₩idowed 4 Divorced "natural" Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working if the DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be Department of Health and Mental Hy, Important: If item 27 is marked Attany or other *** 17. Father's Name (First, Middle, Last) ames Price Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Jala 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee · Greene Funeral Services Signatuy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or hear ailure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 movins?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Records, 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate I 1 ☐ Yes 2 ☐ No Yes Vital Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ot 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural work? 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Regis ar's Signature State Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ap 4 የ 6, 2010 Emmett Eugene Prenger 3:27 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 6. Sex if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth 220-20-1996 1 M 2 D F Months Days Hours Min 81 6/13th 19/28 ar Director Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8315 Dalesford Road items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", White 3 Divorced 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Vice President Mercantile Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Eunice Rowena Collier and Mental ဥ J. Vincent Prenger Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Dolores A. Prenger / Wife 8315 Dalesford Road Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4/9/2010 Timonium, Maryland 4 Donation 5 Other (Specify) Dulanev Valley Mem 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Dav 5 Other (specify) detached the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? by Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 2 prior to completion of cause of death?

1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certified completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 200 မှ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Sther (Spe 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural work? iniury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21200 31. Date filed (Month, Day, State 32. Registrar's Signature Registrar APR 0 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Cameron Apri1 2010 John Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise Nursing Home Montgomery Silver Spring Social Security Number 7. Age (In vrs. last birthday Date of Birth 9. Birthplace (State or Foreign Days 1 🕅 M 2 🗆 F Hours (Month Day Year) 6/9/15 Maryland 125-05-3729 94 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Prince Georges University Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6702 Queens Chapel Road 20782 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 If Yes, Give 2 No 1 ☐ Yes 2: ☐ No Specify. 3 ₩ Widowed 4 □ Divorced WW TT White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Loan Analy</u>st Agricu1ture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Halsey Edmond Ramsen Ruth Cameron Ramsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Springfield, Virginia Mrs. Janet Woods / Daughter 7513 Long Pine Dr. 22151 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/6/10 Baltimore Crematory Baltimore, Maryland . Signature of Funeral Service Lide 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or of shock, or heart failure. List only nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death
4 Months

Physician Medical Examiner

Funeral

Director

show

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at

than "natural",

and Mental F

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other traw

death

72 hours after

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

and I-transit attending physician for use as the buria the ed by til signed b page 2 s

Examine Physician/Medical þ Completed

Be

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Certificate:

Medical

29a. Certifier

this certificate funeral After

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director: / the Hospital

Sequentially list conditions if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

Dementia

25. Was case referred to medical

Gastrointestinal Bleeding

disease or condition resulting in death)

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Due to (or as a consequence of):

Due to for as a consequence of:

Due to (or as a consequence of):

5 Other (specify) Pregnant at time of death Unknown

3 Ectopic pregnancy

Athersclerotic Cardiovascular Disease

Month Day 23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

24a. Was an

1 Yes 2 10 3 Probably 4 Unknown

Year

autopsy performed 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

examiner? Other: 4 Nursing Home 5 Residence Hospital: 2 🖾 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signatuj

D53367

29c. License numbe

April 5, 2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Georgia Ave., Suite 113 Silver Spring, Maryland 20902 9801 Shvamsunsar Rajan

State

Registrar

31. Date filed (Month, Day, Year) APR 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12,19b per fh g903 5-26-10 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:45 P M 0 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical altimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 6. Sex 1 A M 2 □ F 1 27 1 8 Year 4 4 Days Months Marvland Director 228-58-4387 65 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 X Yes 2 No Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21221 U.S.A. 40 Barnacoe Court death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. "natural", or à 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 M No Specify: Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City 10th Grade Road Maintenance should be filed with and Mental Hygien is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernice D. Smith Joseph H. Simms Sr. permit. Page 1 and 2 should the Department of Health and Me Important; If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f 2122119a. Informant's Name/Relationship (Type, Print) Barnacoe Court, Baltimore, MD 21217 Anna Simms(Wife) 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State any injury or 04/13/10 4 Donation 5 Other (Specify) Mt.Zion Cemetery Baltimore, MD 21. Signature of Funeral Service Licensee ²²JOSepHdreHofFaBrown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Metastatic Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Duc to (or as a consequence of): Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🙀 No 1 Marient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature Medical Doctor ess of person who completed cause of death (Item 23a) (Type, Print) N State Registrar

10-02462
Alay Sime

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Alex Sims		I-For State Registrar	State	of Maryland		tificate of		na went	ai nygierie	Reg. N	201	0 1064
Physician	1/	Decedent's Nam	e (First, Middle,Las	Alex		Sims			2. Date of Month	of Death Da h 28, 20	y Year	3. Time of Death 1532 hrs
		4a. Facility Name (e street and number	er)		4b. City, Town,			1 20, 20	4c. County of De	ath
Funeral	4	5. Social Security I		ledical Center	Age (In yrs. la	ast birthday)	If Under 1 Ye	ear If Under		of Birth(M	Гол	Birthplace (State or
Director				M 2 F	47	Yrs	Months Da	ays Hours	Min. 3-5	5-196	63	eign Country) M.D
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ne Maryland or 28a-f show fied at once.	힐.	MD 10e. Street and Nu	n	a 	Bal	timore	10f. Zip Code			100.0	Citizen of What Co	1 Yes 2 No
±			arkside	Drive			212			l sg. v	USA	
eath with the items 23a	Funeral	11. Marital Status 1 X Never Marri	ed 2 Married		s?				n? (Specify Yes Puerto Rican, et		14. Race - Am White, etc.	erican Indian, Black,
after de	요 고	3 Widowed		1 Yes If Yes, Give Year or Dates:	2 X No		Yes 2X				Specify:	Black
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within within gree.	Completed	9th gr			na	un	employ		Name (First, Mi		nemplo	yed
21215-0036 Juld be filed within 7 Mental Hygiens marked other than te event, the Medica	g Re	James	Lee Sim	s				Shir	ley V.	Bag	ley	
MD 21 nd 2 should alth and Me im 27 is ma] ۵	19a. Informant's Na Latony		Type, Print) ms-daug	hter		,				City or Town, State t Balto	ate, Zip Code) 0 , MD 21224
rre, N s 1 and 2 of Health If item	İ	20a, Method of Dis			20b. F	Place of Dispos	ition (Name of oner place)	cemetery,	Date 4-3-20	20	c. Location - City Lansdow	or Town, State
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed withi Department of Health and Mental Hygione. Important: If item 27 is marked other trinipury or other traumatic event, the Med	-		Other Specify	lega"	Mt		lame and Addre				st F/H	21202
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Examiner		or condition resulti	ng in death)	Due to (or as a co	nsequence of	f):	110 vase	diar di	Locabe			
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ed ssit	តា 🛭	(Disease or injury to events resulting in	that initiated C. death) Last	Due to (or as a cor	nsequence of	f):			<u></u>			
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3760, ificate be g physic s the bur	Mec	IF FEMALE: 23b. Was decedent		23c. If yes, out	come of pregi	nancy	tal death		pregnancy		23d. Date of deliv	ery Day Year
Box 68760, ne death certificate be the attending physic hed for use as the burned.	Physician/	past 12 months			at time of de		her (Specify)			- 1		
that the daned by the detached		Part II. Other sign	ificant conditions			esulting in the u	underlying cause	e given in Part	1 I. 23e.	_		to the cause of death?
Division of Vital Records, P.O. ra and or Attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	ted by								1	Yes 2 Was an	24b. Were	autopsy findings available
ecord	ompleted							·		autopsy performed Yes 2	d? death	
tal R	:) L	25. Was case refer examiner?		Hospital:				I Other (Check only one)			
of Virginia Physic	의	1 Yes 27. Manner of Dea	2 No	28a. Date of I	niury	ER/Outpatient 28b. Time of I		njury at Work?	Nursing Home 28d. Des		injury occurred	ner:
Sion Attendin death. ctor: A by the fu	ertification:	1 Natural 2 Accident	5 Pending Investigat	ion				Yes 2 1		tion (Street	ot and Number or	Rural Route Number, City
Divisital or / urs after al Dire		3 Suicide 4 Homicide	6 Could not determine	be	' Injury - At no	ome, farm, stre	et, factory, office	e building, etc.		own, State		Aural Route Number, Oity
	<u>sa</u>	29a. Certifier (Check only one)	Certifying Physic Medical Examine	ian: To the best of r:On the basis of e	my knowledo xamination a	ge, death occur nd/or investiga	red at the time, tion, in my opini	date and plac	e, and due to the	e cause(s) , date and	and manner as si place, and due to	ated. the cause(s)
To the within To the comple	Medical	29b. Signature and		and manner state	ed.			nse number			d. Date signed (M	
		Panelly 30 North	Touchall,	MU	of death /lia-	1233)	0.0	C.M.E.		M	larch 29, 2010)
		30. Namé and add Pamela E.	ress of person who Southall, MD	Assistant Me		miner 11		et, Baltimo	ore, MD 212	01		_
Sta	te	31. Date filed (Mon	# 13°7°5011	3. Regis	trar's Signa	re par	4					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 3 Day Leroy Scott 2/36 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death timore 8. Date of Birth Sex 1 M 2 □ F 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** (Month, Day, Months 9 Director or 28a-f show 10a. State 0b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Directo 1 Yes 2 II No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. Armed Forceş? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin 2 No Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT, use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ (sister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 2010 21. Signature of F neral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Multiple Myeloma Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying y physician and is the burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 🗆 No been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital: 2 🗔 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the pasis of examination and on investigation, in my optimizing control of the cause (s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated. nSRAMPAINSM'D 29b. Signature and title of certifier 29c. License number DD057465 4/1/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Baltimore, MO-21209 2835 Smith N.S-203 NS RajapakstiM.D

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De	partment of l			2010	1 1061.0
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of t	Dealii	2. Date of Death	eg. No. C U 1	10649
	Physicia		Helen Ann S	Staley		Month April	Day 1, 2010	3. Time of Death 11:05A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, o	or Location of Death	APILL	4c. County of Deat	
			Gilchrist Nursing Center	Towso	n		Baltimo	ore Co.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		219-22-6712 Sull Residence of Decedent			Aug. 3	Year) 1,1928 Ma	ryland
	at at	5	10a. State 10b. County 10c. City, Town or	Location	-			10d, Inside City Limits
	faryla Ba-f tified	ect	MD Baltimore			Dun	da1k	1 ☐ Yes 2 ☒ No
	the N	₫	10e. Street and Number	10f. Zip Code			Og. Citizen of What Co	ountry?
	s 23a	Funeral Director	6767 Woodley Road		21222		United S	States
	death item ner m		11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Spe an. Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame	
36	after I", or xami	d by	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2x No		,	Black, White Specify:	White
8	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at	Completed	real of pates.	cedent's Usual Occup	nation			
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ğ	filed al Hy d oth	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
Хa	ould be filed within 72 hours after death with the Maryland dd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25a or 28a-f show matic event, the Madical Examiner must be notified at	욘	John L. Staley		Ire	ne Allen		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		19a. Informant's Name/Relationship (Type, Print) 19b. Mi 19b. Mi 15t.	ailing Address <i>(Street</i> 7 Wharf Ro	and Number or Rura ad Ocean	Route Number, City, M	City or Town, State, Zip aryland 2	21842
ē,	1 and of Hea item			position (Name of		Date 2	20c. Location - City or	Town, State
Ē	Page nent c ant: If	Щ	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, c 4 ☐ Donation, 5 ☐ Other (Specify) Sacred	rematory or other place. Ht. of Je	sus Cem.	4/7/10	Dundalk,	MD
Balt	Departi Departi Importi any inji		21. Signatur por uneral Service Licensee	22. Name and Addre Duda-Ruck	ss of Facility Funeral	Home of	Dundalk. 1	Inc.
		-	23a. Part 1. Enter the disease, or complications that caused the death. Do not e				Dundalk, I Maryland 2	4
			shock, or hear failure. List only one cause on each line.	1977		respiratory arres	,	Approximate Interval Between Onset and Death
7	Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	euken	29			Weks
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	d it d	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				71	
b.	ecute and I-trans	xar	Cause (Disease or iinjury that initiated events c					
	be ex sician buria	call						
20	icate g physis the	ledi	d					
200	certif inding use a	n/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Пе			23d. Date of del	ivery
X POX	death e atte ed for	sicie	I LI IES Z AVINO	Other (specify)			Month	Day Year
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7 <u>.</u>	es tha signed be de		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause gi	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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Records,	has t	Completed by				24a. Was an autopsy perform	prior to d	copsy findings available completion of cause of
ř	n: The ficate or, pag		25. Was case referred to medical	00 DI		1 □ Yes 2		2 🗆 No
NE A	rsicia s certi directo	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Oth	er:		ce 6 Other (Speci	m Gilchris
5	g Phy erthis neral c		27. Manner of De th 28a. Date of injury 28b. Time	of 28c. Injury	y at 2	8d. Describe how	7	Ty) (0 17C 1/1 (3)
0	endin eath. or: Aft	fica	2 Accident Investigation		Yes 2 □ No			
VISION	or Attu	Certificate:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	2	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
5	spital on spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	n occured at the time	, date and place, and	due to the cause	(s) and manner as sta	ted.
;	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check /2 ☐ Medical Examiner: On the basis of examination and/or involved only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinic	on, death occurred at	the time, date and	place, and due to the c	ause(s) and manner stated.
	5 2 with		29b. Signature and hitle of certifier	29c. License	number	290	d. Date signed (Month)	, Day, Year)
			On Normand address of posts of the control of the c	Dried)	40104		T/1/20	10
	12		30. Name and address of person who completed cause of death (Item 23a) (Type	SP SU	to 410	K Ba	Stimore,	m) 21204
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	00		1	(
	Registra	r	APR 0.7 2010 /2 44 A. BON	4				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Day 2010 ear Physician/ April 1 6. 7:00 John O. Simons Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) Director 219-14-6999 85 Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🔀 No Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11630 Glen Arm Road 21057 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic marks. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Contractor <u>Self Employed</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Oliver Williamson Simons Lillie Neff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18509 Kilt Terrace; Olney, MD 20832 William Simons son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🖔 Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4/7/2010 Towson, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MYOCARDIAL INFARCTION Physician/ disease or condition DAUS Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ funeral director, page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Yes 2 N 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 St-Other (Specify) Certificate: To I 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPIGE after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 1 Secrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cartifying Nurse Practioner: To the best of my knowledge, dieth onturn dat the time idate and place, and due to ti or by one 29b. Signature and title of certifier D64395 APRIL 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MO 6701 N CHARLES ST, SUITE 4105 BALTIMERE, MO 21204 31. Date filed (Month, Day, Year) egistrar's Signatu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 30 2010 Carolyn Julia Steiner March 11:47PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Days Min. (Month, Day, Year) 06/27/1940 69 **Director** 214-38-5705 Yrs. Usual Residence of Decedent or 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eximiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Harford Edgewood 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? Funeral 1970 Chipper Drive 21040 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Reynolds Steiner Harry Josephine Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joey R. Brown / Daughter 1970 Chipper Drive, Edgewood, MD 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatony Gifts Registry 04/05/2010 | Hanover, Maryland 21. Signature of Funeral Service License Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanvoer, MD 21076 23a. Part 1. Enter the disease excomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition LARYNX CANCER Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year 1 Yes 2 X Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death?
1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

JACKIE JONES, CRNP

31. Date filed (Month, Day, Year)-

31

MARCH

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2010 April Physician/ 5 RITA KATHERINE TRAVIS 3:05P Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 M 2XX Days Hours 0ct. 17, 1918 Pennsylvania **Director** Yrs. 204-09-8679 91 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes XX No Maryland | Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 2127 Chapel Valley Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify: White 3XXWidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Commonwealth of Pennsylvania Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Loftus Bridget Duffy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Travis Liss DTR 2127 Chapel Valley Lane Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 KK Burial 2 Cremation 3 Removal from State Cathedral Cemetery April 10/2010 Scranton, Pennsylvania ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of F钟itchell-Wiedefeld Funeral Home Inc Ignature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediate Cause (Final ₽h, sician/ Extensive Subarachnoid Mmarch disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner putusive Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury or as a pone-common of Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 💢 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 € Other (Specify) after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 📈 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 4,2010 CRNP R149194

State Registrar 57

Towson,

MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

raian Grant

31. Date filed (Month, Day, Year)

N. Chalis

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 08: Shelley Mae Womack 00 2010 /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner AL LMOYE n/a If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 6–22–1956 Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min 1 □ M 2 🗓 F Davs Hours **Director** MD 218-62-5535 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Maxical Examiner must be profilled at 12 Yes 2 □ No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 USA 35 S. Morley Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 X No Specify. δ 3 Widowed 4 Divorced 72 hours Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cook Kvanger Songer w/ Local 194 permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If item 27 Is marked other the any injury or other traumatic event, If item 2000. 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Bardney Anne Milton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 S. Morley Street, Baltimore, MD 21229 Raymond Womack/ Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-9-2010 Lansdowne, MD Mt. Zion Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Wile Funcial Force P.A. of Palto. Co., . 9200 Liberty Road, Randallstown, MD 21133 23a. Parf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** strake Vascular ualcuoun /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to infinedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed Due to (or as a consequence of) burial-1 *NOMACK* Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mon Month Pregnant at time of death 5 Other (specify) detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown page 2 should Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform 2 140 1 🗆 Yes 20 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manne Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 A Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier M

State

900 South Cate
31. Date filed (Month, Day, Year)

Catra Avenue fattura
Day, Year)

32 pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manyland 21229 Strijay Pathani,

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 2010 12:10a M William D. Andersen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Dove House Westminster If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🖾 M 2 🗆 F Months Days Hours July 29 Washington Director 213-92-2103 47 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No <u>Marylan</u>d Frederick Mt. Airy ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4001 Lomar Drive United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or ₽ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 K Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) President/Owner Flooring Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael C. Andersen Darlene R. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Dieren/ Mother 752 North Mesa Road, Millersville, MD 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc.3/18/2010 Frederick, Maryland Signature Juneral Service Licensee 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike, P. A. Frederick, Maryland21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician hronic Myelpgenous our years disease or condition Medical resulting in death) Due to (or as a consequence of **∕**Examiner Sequentially list conditions, Examine than leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of/ -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 - Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perforn certificate 1 Yes Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 □ Nursing Home 5 □ Residence 6 🗷 Other (Specify) Hospice After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)005239 eM(2010

DHMH 17 Rev 7/2009

State

Registrar

10

Mark Levis MD 1650 Orleans, Street, Baltimore, Maryland 21287 Room 243

32. Registrar's Signature

PARKING.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 2

State Registrar 12150 Annapolis Rd. Suite 312, Glendale, MD 20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rointan Farahi-Far, M.D.

31. Date filed (Month, Day, Year)

MAR 2 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O3 Physician/ 2328 Vera L. Beatty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HILEGOUS WMHS-Regional Medical Center Cumherlana If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 29 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Hours Director 234-40-3324 84 Keyser Jan. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🛣 No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral Rt. 5, Box 700 Waxler Road 26726 items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates. White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Ralph S. Markle Blanche E. Miller Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti Kathy Toma/ Daughter Shannon Place Charleston, WV Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🌠 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 2010 Potomac Memorial Gardens Keyser, WV 21. Signature of Europe I Service License 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Aspiration Immediate Cause (Final Neumonia Physician/ disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Sequentially flat conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir the Hospital or Attending Physician; The law requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of): resulting in death) Last burial-1 physician a Physician/Medical Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death is certificate has been signed by the director, page 2 should be detached g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) health Center, 12500 Willowhook Rd, Cumher West Maryland

Registrar
DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day, Year)

APR O

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 30 2010 ear **Physician** JOHN SIDNEY BEDWELL, JR. 2:40P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHARLES 8619 OUEENSWAY COURT WHITE PLAINS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | 9 - 18 - 1946 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** INDÏĂNA 312-50-4558 63 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at MD. 1 □Yes 2X No PRINCE GEORGES OXON HILL Director 10f. Zip Code 10e. Street and Number 10g Citizen of What Country? 20745 U.S.A. 552 WILSON BRIDGE DRIVE death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian e filed within 72 hours atter de la Hygiene. Black, White, etc. 1 □ Yes 2 □ No USAF If Yes, Give Year or Dates: 1967-71 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 ▼No Specify. Specify: WHITE 2 3 ☐ Widowed 4 ♥ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DEPT.OF AGRICULTURE Elementary/Secondary (0-12) College (1-4or 5+) U.S.GOVT. PROGRAM ANALYST 12 marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN S. BEDWELL, SR. BERNICE M. FICKER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NATALIE SITKOWSKI-DAUGHTER 8619 QUEENWAY CT. WHITE PLAINS, MD. 20695 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 4-4-2010 ALEX., VA. 21. Signature of Funeral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** reast Cancel /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy P in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No page 2 s has autopsy certificate 2 No Division of Vital 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) diaughters home Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury he Hospital or Attending P in 24 hours after death. he Funeral Director: After t pletely filled in by the funera 27. Manner of De th 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ည 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 03 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

24 8x1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death Physician/ Month Helen Bower 2300m Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 120 West Street Allegany LaVale 5. Social Security Number Birthplace (State or Foreign Country)

DE If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 □ **y** (Manth, Day 2 2 1939 **Director** 213-40-2722 70 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director LaVale MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d Mental Hygiene. marked other than "natural", or items 23a Funeral 120 West Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Completed 3 Divorced 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) teacher School System permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank B. Altice (Stull) Altice Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
120 West Street LaVale MD 21502 Richard Bower husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
SS Peter & Paul Cemetery 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4/3/2010 MD Cumberland 4 Donation 5 Other (Specify) 21. Sigulure of Tuneral Serio Licensee 22. Name and Address in Full Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner cut Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertensin 1 Tes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 021244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 401-2010 Pay 2:35 PM Marjorie Ε. Boyer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Homewood at Crumland Farms Frederick 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min 1^M20, Pro 23 212-82-4203 England Director 87 Usual Residence of Decedent 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick Frederick MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 7401 Willow Road USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker it. Page 1 and 2 should be filed wi irtment of Health and Mental Hygie irtant: If item 27 is marked other njury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jessica Isabelle Chapell Perciville H. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5503 Corral Lane Frederick, MD 21703 Son Julian Boyer 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl
once. Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 4-3-2010 4 Donation 5 Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Septice Li 22. Name and Address of Facility Keeney & Basford P.A. F.H. MO1176 106 East Church Street Frederick, MD 21701 the . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequer **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🕽 Other မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA ✓ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit of certifier 29d. Date signed (Month. Day, Year) D16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cline III MD 300 West 9th Street Frederick, Maryland 21701 E Casper 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009 2

State

Registrar

32. Registrar's Signature

BB A 9 9hAh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** arch Augusta Estell Brewer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M XXX F Director 214-16-6487 10/17/1917 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental hygiene. Important; If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It I Medical Examinations to other traumatic event, It I Medical Examinations and injury or other traumatic event, It I medical Examinations and Item I was a second to the continuous and injury or other traumatic event, It I medical Examinations are second to the continuous and injury or other traumatic event, It I medical Examinations are second to the continuous and injury or other traumatic event, It I medical Examinations are second to the continuous and injury or other traumatic event, It I medical Examinations are second to the continuous and injury or other traumatic event, It I medical Examinations are second to the continuous and injury or other traumatic event, It I medical Examinations are second to the continuous and injury or other traumatic event, It I medical Examinations are second to the continuous and injury or other traumatic event, It I medical Examinations are second to the continuous and injury or other traumatic event, It I medical Examinations are second to the continuous and injury are second to the conti Director 1 □Yes XXNo DE Sussex Frankford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37324 Alabama DR. 19945 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married □Yes 2 Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White ģ If Yes, Give Year or Dates: Specify 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Cafeteria 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Knoble Lillian Ulrich ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Love Daughter 748 Hyde Park DR. Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4/2/2010 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 4 7 Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and Due to (or as a consequence of): burialattending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: f yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) P.0. 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 12 No 2 No 1 ☐ Yes 1 ☐Yes 25. Was case referred to medical 26. Place of Death (Check only one)

of Vital Division Hospital or Attending

examiner? 1 ☐ Yes 27. Manner of Death

Be

Medical

certificate has been s rector, page 2 should this certific al director, After n 24 hours after death.

Re Funeral Director: Aft bletely filled in by the fur

Certification: To

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

2 1 No

5 Pending investigation

6 Could not be determined

1 Natural

2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

Hospital:

28a. Date of Injury (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Trop, Friht) US. 32. Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐Yes 2 ☐No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

ORIGINAL

within 2 To the F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JOSEPH MARCH 29 2010 RICHARD 8:26 A M BERCIER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6165 CHAPMANS LANDING ROAD INDIAN HEAD CHARLES Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 3 M 2 □ F DEC. 20, 1953 WASHINGTON, DC Director 212-62-1607 56 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director MD CHARLES 1 ☐ Yes 2X No INDIAN HEAD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 6165 CHAPMANS LANDING ROAD U. S. A. 20640 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. should be filed within 72 hours after and Mental Hygiene. 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify ş Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 and Mental Hygiene. College (1-4or 5+) IRON WORKER WELDER CAPITOL WELDING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LYLE JOSEPH BERCIER BETTY LOUISE JAMES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. 6165 CHAPMANS LANDING RD. INDIAN HEAD, MD20640 LYLE J. BERCIER/FATHER altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ST. CHARLES CEM. 6**,** 2010 GLYMONT, MARYLAND 22. Name and Address of Facility RAYMOND FUNL . SERVICE, P . A . 21. Signature of Funeral Service Licensee Bartos osen 8 M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Schen disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 □Yes 2 □ No 1 ☐ Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 __Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10050883 1009001. 1alvia APRIL 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w. wesap of captake up 1165 YAHIA TAGOURI D // strar's Signature Μ. Μ 31. Date filed (Month, Day, Year) Registrar

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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ Kim Baker 1542 2017 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegan NMHS-RMO umber land If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, . Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Country) California 1 □ M 2 👿 F Hours 44 Director 515-68-7039 04/01/1965 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Allegany Cumberland 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11829 Valley Road, NE 21502 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 X Divorced Completed White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Richard Gray Martindale Lee Shirley Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11829 Valley Road, NE, Cumberland, MD Darrell Baker / Ex-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 04/01/2010 Cumberland, MD 4 Donation 5 Other (Specify) Adams Family Funeral Home, 21. \$ign lure of Funeral Service Licenses 22. Name and Address of Facility 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) hours -Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit Emphysema and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) q 🗌 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2×100 Hospital: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) per D. A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Victoria M. Wiley

APR 0 1 2010

31. Date filed (Month, Day, Year)

Cumberland, MD

21502

621 Kelly Road,

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	of Mary		artment of F ertificate of			giene Reg. No. 2	nin	10664
			Registrar Decedent's Name	(First, Middle,	Last)					2. Date of De	ath	0 1 0	3. Time of Death
	Physicia		_		eler					March	17, 20	010 ^{Ye ar}	3:45 P M
	/Medic Examin		4a. Facility Name (If I			mber)		4b. City, Town, o	r Location of Death		4c. Coun	ty of Death	1
		٠.	300 Jaso	ntown I	Rd.			Westmins	ter		Carı	roll	
	Funeral		5. Social Security Nu	mber 6	i. Sex 1 ☐ M 2 ☐ x F	7. Age (Ir 93	yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	Coui	place (State or Foreign htry)
	Director		221-10-339		I I IVI Z LAN	93	Yrs.			Nov.	30, 191	6 DE	
pue	M. T		Usual Residence of E 10a. State	10b. County		10	c. City, Town or L	ocation				1	0d. Inside City Limits
Mary	-fsho	현	MD	Carrol	1	l	Westmins	ster					1 ∐Yes 2 DXNo
att c	r 28a	Director	10e. Street and Num	ber				10f. Zip Code			10g. Citizen o	f What Cour	ntry?
ži.w.	23a o	a	300 Jaso	ntown :	Rd.			21158			U.S.A.		
d 21215-0036 filed within 72 hours after death with the Maryland	perference ragger lands about the mean while rathered are regard to the short man the mean year important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed 4		12. Was Dec Armed F d 1 □ Yes If Yes, G Year or I	orces? 2 14No ive	in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 XNo	dispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	BI	ace - Americ lack, White, cify: Whi	etc.
21215-0036 d within 72 hours aff	e. an "natura Medicel E	Completed	(Specif	, , ,	grade completed,) (1-4or 5+)	16a. Dec (Giv life.	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of work d)	king	16b. Kind of	Business/In	dustry
21.	giene er the	ĕ	12	dai y (0 12)	00090		Home	maker				Home	
Maryland	Mental Hy rked oth	To Be (17. Father's Name (F Frank McCu						18. Mother's Nam Edna Ma :	ne (First, Middle rtin	e, Maiden Surna	ame)	
, Mar)	ealth and 127 is male traums		19a. Informant's Nar G. David					ling Address (Street Jasontown				n, State, Zij 2115	
altimore,	nent of He nt: If item		20a. Method of Dispo 1 ☐ Burial 2 ☑ 4 ☐ Donation	Cremation 3	B ☐ Removal from		20b. Place of Disp cemetery, cri CarrolI	position (Name of ematory or other pla Cremation	% 3/1	.9/2010	Hampst		
Balti	Departru Importa any Inju		21. Signature of Fu	Feral Service Li	Densee			22. Name and Addre 112 Wa shi r					Chapel, PA 1157
9	hysician and hysician and the private franching the private franch	dical Examiner	23a. Part1. Enter the shock, or hear Immediate Cause (f disease or condition resulting in death) Sequentially list conit any, leading to irring cause. Enter Under Cause (Disease or list that initiated events resulting in death) Li	t failure. List o Final ditions, necrate lying njury	a. Due to	each line.	onsequence of):		ng De	/			Approximate Interval Between Onset and Death
Box 6	a attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 ℤ 9 □ Unknown	nenths?		birth 2 D gnant at tim	Fetal death 3	l ☐ Ectopic pregnan i ☐ Other <i>(specify)</i> _	су			Date of delive	very Day Year
rds, P.	s been signed b	þ	Part II. Other signific	cant condition	ns contributing to	death but n	ot resulting in the	underlying cause gi	ven in Part I.				the cause of death? bably 4 Unknown
Division of Vital Records,	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed								24a. Was auto perf	opsy formed?	b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
Vita	sertific ector,	Be	25. Was case referre		Hospital: 4			Ot	26. Place of Dea				
Of Phys	this aldir	유	1 Yes 2 11 27. Manner eath		1 1	Inpatient e of Injury	2 ER/Outpat	ent 3 L DOA	4 Li Nursing F	lome 5 Thes	how injury occ		ify)
on of	h. After thi funeral o	tion	1 tural	5 Pending investiga	(Mo	nth, Day, Ye		/ Wo	rk?]Yes 2. □No	20d. Describe	, now injury ooc	Juli 0 G	
Division	n 24 hours after death. P Funeral Director: A pletely filled in by the fu	Certification: To	2 Accident 3 Suicide 4 Homicide	6 Could no determin		ce of Injury ding, etc. (l - At home, farm, s Specify)	street, factory, office		28f. Location City or To	(Street and Nu own, State)	mber or Ru	ral Route Number,
Hospita	within 24 hours after To the Funeral Directory completely filled in	Medical C			xaminer: On the		amination and/or	ath occurred at the investigation, in my					
To the	withir comp	Me	29b. Signature and	vile of certifier					se number		29d. Date sig	1	, Day, Year)
1	5		30. Name and addre		vho completed ca	use of deat			c) (ustm	nt	pn 6	2:157
*	Sta Registr		31. Date filed (Mont			Registrar's	- 00	bare					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 2010 12:05 AM Paula Stonestreet Bruncsak March 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil 156 Green Haven Drive E1kton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country Baltimore Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 20XF Yrs. Director 1948 220-46-9498 Nov. 19. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits work rthan "natural", or itama 23a or 28a-f ahov the Madical Examiner must be notified at 1 □ Yes 2√√No E1kton Maryland Cecil Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21921 United States 156 Green Haven Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within in and Mentel Hyglane. Elementary/Secondary (0-12) College (1-4or 5+) of Heelth and Mentel Hyglar If Itam 27 is marked other ti or other traumatic event, the Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 Guy Wilmer Stonestreet Rosemary DiPaula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph C. Bruncsak / Spouse 156 Green Haven Drive, Elkton, Maryland 21921 Baitimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) March 27, 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges 'Department of H Important: If its any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2010 4 Donation Mayerdale Crematory Newark, Delaware 21. Signature of Puneral Service Licens 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician Menown disease or condition resulting in death) ances /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician end for use as the buriel-transit resulting in death) Last Due to (or as a consequence of): certificete be exe Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) signed by the a of Vital Records, P.O. 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown s peen si should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 1 Yes 2 No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes ਚੋ ဥ this After thi 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of ha Hospital or Attanding P n 24 hours efter deeth. na Funaral Diractor: After th 27. Manner of Death Certification: Division Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my sale 29a. Certifier To the Hosp within 24 hou To the Funa completely fil (Check only one) niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

dimonson

DHMH 17 Rev 1/2001

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133 N.

32. Registrar's Signature

ass of person who completed cause of death (Item 23a) (Type, Prig

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia G. Beatty 15:29 March 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) av 23,1936 1 □ M 2 🛭 F Months Days Hours Min. Director 161-28-4594 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shor Examiner must be notified at 10d Inside City Limits Director 1 X Yes 2 No Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9913 Goldenwood Ct. 20772 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Completed by Yes 2 XNo permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural" 3 Widowed 4 Divorced 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Pasquale Giuliano Lucy Susco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Beatty 9913 Goldenwood Ct. Upper Marlboro, MD 20772 Health a (Husband) item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Chesapeake Crematory: 3/27/2010 4 Donation 5 Other (Specify) Beltsville, MD Rendon/Hale Funeral Home Signature Funeral Service Licenses 22. Name and Address of Facility 9013 Annapolis Rd. Lanham, MD 20706 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List, the cause on each line. Approximate Interval Between Onset and Death ock, or heart failure. List mediate Cause (Final Physician/ disease or condition resulting in death) mon Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical that the death certificate be Box 68760 the use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ed by the atten in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Av Thaitis 51016 Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? he, mek 24a. Was an performed? Yes 2 N 2 ANO 1 🗌 Yes Division of Vital Hospital or Attending Physician: To Be completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After t 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier .0 198 MD 0

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 2 5 2010

32. Registar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Thomas F. Couzens, Jr. 2010 11:45 PM Medical March 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)

M.J. **Funeral** Days Min. Hours 1**XX**M 2 □ F 7-6-1931 Year 216-28-7474 **Director** 78 Yrs Md. Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2X No Wicomico Salisbury Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21802 USA 900 Booth St. or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 2 □ No 1952þ 1 Never Married 2 Married 1X Yes 1 Yes 2 No Specify: "natural", 3 Widowed 4X Divorced 1954 Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ! Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Design Architect Be permit. Page 1 and 2 should be filec Department of Health and Mental Hy Important: If item 27 is marked oft any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Thomas F. Couzens, Sr. Gertrude Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28263 Adkins Rd. Salisbury, Md. 21801 Colleen P. Ellis, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State March 25, 201/0 4 Donation 5 Other (Specify) Springhill Memory Gardens Hebron, Maryland 22. Name and Address of Facility
Short Funeral Home, 13 E. Grove St. Delmar,
19940 21. Signature of Funeral Service Licenses DE. oseph m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year by the Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy perform certificate 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ٥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural work? 1 ☐ Yes Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours
To the Funeral State

DHMH 17 Rev 7/2009

Registrar

Medical

29a. Certifier

only one) 29b. Signature a

31. Date filed (Month, Day, Year)

910 Easternshore Dr

egistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesha Thimmarayappa M.D.

4

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Salisbury

MD 21804

29d. Date signed (Month, Day, Year)

40 00474	
10-02474	

Christian Hamilton Dean

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

usc	Type of I fille in Di	ack machine mik.	Lilouic All O	phies wie
	State of Maryland	/ Department of He	ealth and Menta	al Hygiene

2	0	-	0	-	0	6	6	
Lungs	0	R		ř.		-	_	

		1- For State Registrar		Cert	ificate of	Death		,	Re	9. No.	JI	U lubb
Physicia ledical Examin	n/	1. Decedent's Name (First, Midd	Hamilton Dean	1					2. Date of Deal Month March 29 ,	Day Ye	ar	3. Time of Death 0939 hrs
		4a. Facility Name (if not institution 1725 Manchester Road)				4b. City, Town, o			inster	4c. County Carroll	of Death	1
Funeral Director		5. Social Security Number 213–80–9778		(In yrs. las 37	t birthday) Yrs	If Under 1 Ye Months Da		Min.	1	th(MM/DD/YYYY 7, 1972	Foreig	thplace (State or on New ^{untry)} Jersey
w any		Usual Residence of Decedent 10a. State 10b. County		Oc. City, T	own or Locat	ion			•			10d. Inside City Limits
Maryland 28a-f show 1 at once.	탏	10e. Street and Number	rroll			10f. Zip Code	Manch			09. Citizen of W		1 Yes 2 No
with the l	ᅙ	2595 Mindi Driv	VE 12. Was Decedent Ev	ver in U.S.	13. Wa	s Decedent of H	21102 lispanic Orig		cify Yes or No-		SA e - Ameri	can Indian, Black,
offer death	by Fune	1 Never Married 2 MM 3 Widowed 4 Div	Armed Forces? 1 X Yes 2 vorced 1 Yeserat St	orm	1	es, specify Cuba	an, Mexican, o specify:	, Puerto R	Rican, etc.)	Whit Specify:	e, etc. Wh:	ite
6 n 72 hours a an "naturi ical Exami	Completed b	15. Decedent's Education (Spe Elementary/Secondary (0-12)			during m	t's Usual Occupa ost of working life	e. DO NOT	use retire		16b. Kind of Bu	ibut:	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica		12 17. Father's Name (First, Middle Ellwood Rurke	, Last) eholder Dean,	.Tr	Oper	ations N	18.Mother	s Name (First, Middle, N	Maiden Surname		materials
MD 212' d 2 should be Ith and Menta n 27 is marke	To Be	19a. Informant's Name/Relations Krystal M. Dea	ship (Type, Print)	01.		Address (Stre Mindi Di	eet and Num	ber or Ru	ral Route Num	ber, City or Tow		, Zip Code)
ore, M ges I and 2 of Health: If item 2 ther traun	1	20a. Method of Disposition 1 Burial 2 Cremation		cre	ace of Dispos ematory or oth	ition (Name of ce	emetery,		Date	20c. Location Churchy	- City or	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho njury or other traumatic event, the Medical Examiner must be notified at once.	_	4 Donation 5 Other S 21 Signature of Funeral Service		Gree	22. N	lame and Addres	ss of Facility	Mve	ers-Durl	oraw Fi	uner	al Home
Physician //Medical	1	23a. Part I. Enter the disease, or failure. List only one cause	on each line.		o not enter th	ne mode of dying						Approximate Interval Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent		injur	ies						
	힐	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated	C.									
ecuted and transit		events resulting in death) Last	Due to (or as a consequent			- 01.10	1 /001	2 ~				
760, icate be executed physician and the burial - trans		X UNPENDED	X AMENDED Item 23a.	m 4b 27.28 of pregna	per M. a-f.pe	E. U4/U	432	0 Ca 3/10	TT (23d. Date of	delivery	
ox 68 ath certif attending or use as	ysician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unl	he 1 Live birth 4 Pregnant at tim known 9 Unknown	ne of deati	, - =	tal death 3 ner (Specify)	Ectopic	pregnand	су	Month	D	day Year
P.O.	≥	Part II. Other significant condit	ions contributing to death b	ut not resu	ulting in the u	nderlying cause	given in Par	rt I.		pacco use contr	_	the cause of death? ably 4 Unknown
of Vital Records, ng Physician: The law require Utler this certificate has been si meral director, page 2 should b	Completed								24a. Was a autops	sy r		topsy findings available ompletion of cause of
ician: The law	Re Co	25. Was case referred to medica examiner?				26.Plac	e of Death (1 ✓ Yes 2	No 1	✓ Ye	
of Viting Physici	아	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury		R/Outpatient 8b. Time of Ir		Other ₄			Residence 6		Scene
- 3 . ~ 2	Certification:		stigation Fd 3/29/1	lO I	Fd 9:24	4 am 1	Yes 2 X	No S	ubject	fell do	own :	stairs
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide deter	rmined (Specify) dv	velli	ng			1	or Town, St Manches	ate) 1724 ter, MD	Manc	hester Rd
To the Hawithin 24 To the Facompletel		(Check only	hysician: To the best of my ki miner: On the basis of examin and manner stated				n, death occ			ind place, and d	lue to the	e cause(s)
MIL		Theodore M	King The	w	δ.		.M.E.	OCM	Ē	March 30,		nn, Day, Te ar)
		30. Name and address of person Theodore M. King, Jr.	, MD. Assistant Med	dical Ex		111 Penn St	treet, Bal	timore,	MD 21201			
Sta Registr	~	31. Date filed (Month, Day, Year) APR 0 1	2010 32. Registrar's	Signature	ha	11.1						
DHMH 17 Rev 1/200	1				ORIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Zachary Lee Du	kes	1- For State Certificate of Death	ntal Hygie		20 I	0 1067
Physicia Medical Exami			М	ate of Death	Day Year	3. Time of Death 1253 hrs
•		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 25711 Garey Road Denton			4c. County of I	Death
Funeral Director		217-23-4039 1X M 2 F 21 Yrs. Months Days Hour			(MM/DD/YYYY) 9 2,1989	Birthplace (State or oreign XXLAND
nd Show any		Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code		1	g. Citizen of What	
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at onse	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori 1 X Never Married 2 Married 14. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Ori 16. Yes, specify Cuban, Mexican 17. Yes 2 X No. specify 18. Yes, Sive Year	n, Puerto Rica	Yes or No-	14. Race - A White, e	American Indian, Black, etc. WHITE
10 F = 78	Completed by	or Dates:	e kind of work o	done	16b. Kind of Busin	
MD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than matic event, the Medica	Be	GARY LEE DUKES CIN	NDY ANN	NAPIE		
AD 2 sho 2 sho 27 is imati	To	GARY AND CINDY DUKES/PARENTS 109 WOODMOOR ROAD), STEV	ENSVIL	LE, MD 2	21666
≒ # & & ≠ #		20a. Method of Disposition 1	APRIL 2010	/	20c. Location - Ci	ty or Town, State
Baltimo permit. Page Department Important:		21. Signature of F ral Service Licensee 1. Signature Contract Licensee 1. Signature Contract Licensee 1. Signature Contract Licensee 1. Signature Contract Licensee 1. Signature Contract Licensee 1. Signature Contract Licensee 1. Signature Contract Licensee 1. Signature Contract	DAD, CH	ESTER,	MD 2161	19
Physician /Medical Examiner		23a. 1 st Eter the classes, or complication that a sed the death. Do not enter the mode of dying, such as a failure. Later one cause on each line. Combined effects of oxycodon immediate Cause (Final disease a. Oxycodone intoxication methadone	cardiac or resp ne into e use c	oriatory arres Xicati complic	t, shock, or heart ion and cating	Approximate Interval Between Onset and Death
	Į.	or condition resulting in death) Due to (or as a consequence of): cardiomegaly Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
scuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
O, be exe sician	edical	X UNPENDED AMENDED 23a, PII, 27, 28a-f, perm, E g902	erm,E g 2 4/20/	902 4/ 10 TT		
Box 6876(death certificate the attending physical for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ic pregnancy		23d. Date of de Month	livery Day Year
, P.O. B. ires that the de signed by the	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I.	23e. Did toba		te to the cause of death? Probably 4 Unknown
cords law requi	Completed			24a. Was an autopsy perform Yes 2	prio ed? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
Vital Rec hysician: The this certificate	o Be	25. Was case referred to medical examiner? 1 V Yes 2 No	Nursing Hon		esidence 6 🗸 (Other: Scene
Sion of Attending Ph death. ctor: After ti	Certification: T	27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work 1 Natural 5 Pending Investigation 28d. Date of Injury 28c. Injury at Work 1 Yes 2 X	No unk	accid		ntoxication
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		Suicide 4 Homicide 6 Record net be determined 28e. Place of Injury - At home, farm, street, factory, office building, et single family residence 29a. Certifier 1 Certifular Physician: To the best of my knowledge death occurred at the time, date and place.				Rural Route Number, City Garey Rd
To the H within 24 Fo the Fo completed	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death oc and manner stated.	ccurred at the t	time, date an	d place, and due	to the cause(s)
	2	29b. Signature and title of certifier 29c. License number O.C.M.E.			April 1, 2010	(Month, Day, Year)
		Name and address of person who completed cause of death (Item 23a) Carol Allan, MD	21201			
St: Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Sandra Carolyn Dunn 2140 P M March 31 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Laurelwood Care Center Ceci1 E1kton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 K F Days Hours Min. Months Director 159-50-4660 55 DEC 3, 1954 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any Injury or other traumatic event, the Medical Examinat near retified at 1XYes 2 □ No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 927 Singerly Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠓ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔽 No Specify: þ Specify: 3 ☐ Widowed 4 🕅 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) In Her Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Liahue Clayton Gentry, Sr. Geneva Irene Blevins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina M. Gentry/Daughter 37 Hickory Drive, North East, MD 21901 20b. Place of Disposition (Name of cemetery, crematory or other place)
North East
Methodist Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 6, 4 ☐ Donation 5 ☐ Other (Specify) 2010 North East, MD Programme and Address of Facility.
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Signati e of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cordiac Arest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for Month Year Day 5 Other (specify) the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy perform certificate 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 124 hours after death.

18 Funeral Director: A pletely filled in by the fu death. 2 Accident 1 ☐ Yes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Box 68760, P.0. Division of Vital Records, within 24 hor To the Fune completely fi

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

(Mesell

(Check only

29b. Signature and title of certifier

223

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

DHMH 17 Rev 1/2001

State Registrar Christopher S. Vagnoni, MD, 925 Seton Dr., Cumberland, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Marylan	d / Depa <i>Ce</i>	artment of F	Health and Death		giene 2 (10	10673
	Dhysis	ion	1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medi		Dora Alice	Durst					March		010	5:30 ^{P M}
	Exami	ner	4a. Facility Name (If not institution, g		,		4b. City, Town, o	r Location of Deat	h	4c. Count	y of Death	
may or			Moran Manor 1					ternport		A11	egany	
	Funeral			Sex 7. 1 ☐ M 2 💢 F	Age (In yrs.	la <i>st birthd</i> ay) Yrs.	Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th ly, Yea <i>r)</i>	9. Birth	place (State or Foreign ntry)
	Director		232-54-4576 Usual Residence of Decedent		85	113.			Aug. 7	,1924	Ri	dgeville, W
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	10d. Inside City Limits
	Mar)	후	WV Minera	. 1		77						1 Yes 2 □ No
	1 the	Director	10e. Street and Number	11		Key	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	h wit		665 Terrace Di	ive			267	726		TT	7 A	
	ter death with the Marylan Items 23a or 28a-f show	Funeral	11. Marital Status	12. Was Decede		S. 13.	Was Decedent of H		pecify Yes or No	- 14. Ra		can Indian,
٥	after or ite		1 ☐ Never Married 2 ☐ Married	1 ☐Yes 2	No No		1 ∐Yes 2 ⊠ No		o Ricari, etc.)		ck, White,	etc.
Š	72 hours afte "natural", or i	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		ты сэ гдио	ореспу.		Specia	Whi	ite
21215-0036	72 h "natu	Completed	15. Decedent's E (Specify only highest g	ducation ade completed)		(Give	dent's Usual Occup	during most of wor	king	16b. Kind of E	Business/In	dustry
V	vithin sne. ihan	E G	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT use retired	d) -				
V	be filed within 72 ho ital Hygiene. id other than "natu event, the Medical	ပိ	10 17. Father's Name (First, Middle, Las	+1			Clerk	18. Mother's Nar	/First Middle			Stores
and	ould be filed Mental Hyg arked other atic event, I	Be		,							,	
-	should be tiled within 72 hours after death with the Maryland tind Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show umatic event, in Medical Event in a the routiled at	2	Andrew D. Conra			10h Mailir	ng Address (Street		ia Susar			- 0-4-1
	d 2 sho Ith and Ith and Ith and trauma) Code)
Ψ.	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		Betty L. Mills/D	augnter	20b. P	lace of Dispo	Sunset P sition (Name of natory or other place	<u>'Iace Ke</u>	yser, W\	7 2672 20c. Location		own. State
	Pages nent of ant: If It		1 X Burial 2 ☐ Cremation 3 [ate			iApri	1 2		Ť	
Daitimor	교본원들 .		4 ☐ Donation 5 ☐ Other (Spec. 21. Signature of Funeral Service Lice		Pot	omac M	emorial (2. Name and Addre	es of English		Keyse		V
0	Depa Impo any ir		21. Signature of uneral Service Lice	6 11	1	4		Sm	ith Fune		_	
		-	23a. Part 1. Enter the disease, or cor	nnlications that cau	sed the death	Do not ent	85 S. Mai	n Street	Keyse	r, WV	26726	Approximate Interval Between
	hysician /Medical xaminer	Je.	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a Due to (or	as a consequ	ience of):	riphese	al vas	cular	disec	ce	Onset and Death
07.00,	physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ							
DO YOU DO.	attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal nt at time of d	death 3	Ectopic pregnance Other (specify)	у			ate of delive	ery Day Year
Ords, r	s been signed by the should be detached	þ	Part II. Other significant conditions Alzheimeos	contributing to deat	th but not resu	liting in the ur	Amau	en in Part I.		obacco use con ′es 2	tribute to th	he cause of death?
	this certificate has be al director, page 2 sho	Completed							24a. Was autop perfo 1 □Yes	med?	prior to co death?	opsy findings available impletion of cause of
- i	centi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕅 No	Hospital:			t all DOA Othe	26. Place of Dea				
5 8	rthis rald	۲: ا	27. Manner of Death	1 ☐ Inp	natient 2 1	ER/Outpatien 28b. Time of	1 3 LI DOA	4 Nursing H	ome 5 Resid			y)
5 5	Afte fune	tion	1 Natural 5 ☐ Pending	(Month,	Day, Year)	Injury	28c. Injury Work	Yes 2 □No	Zou. Describe i	low injury occur	red	
To Atten	rs after deat al Director: ed in by the	Certification:	2 Accident Investigatio 3 Suicide 6 Could not be determined	e 28e. Place of	Injury - At ho , etc. <i>(Specify</i>	me, farm, stre	eet, factory, office	163 2 1110	28f. Location (S City or Tow		ber or Rura	al Route Number,
he Hoen:	in 24 hou he Funer ipletely fil	Medical	29a. Certifier (Check only one) The Certifying P 2 Medical Exa	hysician: To the be miner: On the basi and manner	is of examinat	wiedge, death ion and/or in	occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the rred at the time,	cause(s) and m date and place,	anner as s and due to	stated. the cause(s)
Ė	Vith COT	Σ	29b. Signature and title of certifier	-			29c. License			29d. Date signe	d (Month,	Day, Year)
			Magranad	Bokil	W.I	J.PK.	D W	V 208	568	04	011:	2010
			30. Name and address of person who	completed cause (of death (Item	23a) (Type, I	Print)					<u>~</u>
			Harshad Boki	L, M.D.,	Ph.D	566	S. Miner	al Stree	t Kevs	er. WV	2672	6
	Sta Registra		31. Date filed (Month, Day, Year)	7 2010 b	istrar's Signat	ure	balls			-,		

DHMH 17 Rev 1/2001

Die

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Physician/ JUDY CAROLYN EASTMAN MARCH 24, 5:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 105 OVERLOOK DRIVE QUEENSTOWN QUEEN ANNE'S If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** July 7,7°350 1 M 2 X F NORTH CAROLINA Director 276-48-2108 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director QUEEN ANNE'S QUEENSTOWN MD 1 Yes 2 No ŏ 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21658 USA 105 OVERLOOK DRIVE items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ō þ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify. 3 Widowed 4 Divorced Completed WHITE Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic execution. Elementary/Seconday (0-12) College (1-4 or 5+) 12 -0-WAITRESS FOOD SERVICE Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည CORRIE CANTRELL H.E. McCARSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $105\ \ OVERLOOK\ \ DRIVE,\ \ QUEENSTOWN,\ \ \ MD\ \ 21658$ ALLEN WAYNE EASTMAN/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MARCH 29, CENTREVILLE, MD 21617 4 Donation 5 Other (Specify) 304 WILLOW BRANCH RD 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Faci FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Momas LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death n signed by the a Id be detached f 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 s autopsy performed? Yes 2 No 2 No certificate 1 🗌 Yes After this certific funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital 2 X No Other: 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending Μ 1 ☐ Yes 2 ☐ No Accident within 24 hours after death

To the Funeral Director: completed filled in by the Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 21601 completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 22 Day 2010 Year Leone Elizabeth Retzel 12:00 PM Eaton Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Chestertown Nursing & Rehabilitation Kent Chestertown Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min. 04/10/192 Director 82 IL 321-22-4971 Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland nd Mental Hygiene. ... marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12401 Still Pond Creek Road 21678 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give ^{Specify:} White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical <u>Secretary</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Leo Retzel Kate Berger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Adams/daughter 25736 Lambs Meadow Rd. Worton, MD 21678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1🛣 Burial 2 🗆 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ I.U. Cemetery 3/27/10 Worton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Fellows, Helfenbein & Newnam Funeral Home Buck Chestertown, MD 21620 130 Speer Rd. Approximate Interval Between Inset and Death 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final INFARCT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Box 68760 attending pi IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month Month 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ontribute to the cause of death? 23e. Did tobacco use Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performe certificate 2 1 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 🎜 Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check the only one Sentifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of 29c. License number 29d. Date signed (Month. 6 Ĉ W. Cell on who completed cause of death (Item 23a) (Type, Print) Chestertown, MD 21620 120 Speer Rd Bldg. B Shanahan Mi 32. Re istrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 1 0 State of Maryland / Department of Health and Mental Hygiene

		I- For State Certificate of Death Reg. No.	
Physicia	n/	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death	
Medical Examin	-	Iris Michelle Flanagan March 16, 2010	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4d. County of Death Allegany	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Fo Country)	reign
Director		N/A 1 M 2 XF Yrs. Months Days Hours Min. March 16,2010 Frostburg,	MD.
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lir	nits
A		MD Allegany Frostburg	No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
the M		17225 Old County Road, S.W. 21532 USA	
th with ems 2.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
9 , 5		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X. No specify: Specify: White	
hours af "natural	함	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
6 172 hc	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	
within giene.	Ĕ.	0 N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	\dashv
21215-0036 Juld be filed within 77 Mental Hygiene. marked other than cevent, the Medical	Be C	Michael Patrick Flanagan Tristan Michelle Apple	
21, bould b d Men is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
and 2 shou cealth and ? tem 27 is retraumatic	-	Tristan Michelle Apple/Mother 17225 Old County Road, S.W. Frostburg, MD 215. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	32
nore, ages la nt of He ut: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place) March 24	
.도 ~ 일 등 등	ŀ	4 Donation 5 Other Specify: Dawson Cemetery 2010 Dawson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home	\dashv
Balt permit. Depart Import	İ	85 S. Main Street Keyser, WV 26726	
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Inte	
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):	
		Sequentially list conditions, b. Group B streptococcus infection	
	ie	if any, leading to immediate Use to (or as a consequence of):	
#	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	\neg
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Box 687 e death certific the attending I	Physician	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown g Unknown	
, P.O. Box 687, res that the death certific signed by the attending be detached for use as 1		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	
ires that	ğ 1	Umbiclical cord hematoma 1 Yes 2 ✓ No 3 Probably 4 Unkno	
cords law requ has been	bet	24a. Was an autopsy findings avail autopsy prior to completion of cause performed?	
tal Rec	Completed by	1 ✓ Yes 2 No 1 ✓ Yes 2 No)
ician: s certif	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other; Which is a contraction of Death (Check only one) Contraction of Death (Check only one) Contraction of Death (Check only one)	7
of V ing Phys After thi funeral d	의	1 ✓ Yes 2 No Thimpatient 2 ✓ Ervoupatient 3 Usb. Time of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred (Month, Day, Year)	
ion tendin eath. tor: A	힕	1 A Natural 5 Pending 1 Yes 2 No	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	3 Suicide 6 Could not be determined (Street and Number or Rural Route Number, or Town, State)	City
Hospita 4 hours Funera ely fille		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
o the Jithin 2 or the Jon the Jonplet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
F 2 F 3	ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 17, 2010	
		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Regist		APR 0 7 2010 Genera S. James OCME	
DHMH 17 Rev 1/20	001	ORIGINAL	

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

or 28a-f show

d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at

27 is marked other at traumatic event, in

Department of Health Important: If Item 27 any Injury or other tronge.

Funeral Director

Be Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Marylan: nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

10a State

MD

burial-trar attending physician for use as the burial certificate has been signed by the rector, page 2 should be detached within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

Hospital or Attending Physician: The law requires that the death certificate be executed

the

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Division of Vital Records, P.O. Box 68760,

Examiner Be Completed by Physician/Medical Medical Certification: To

25. Was case referred to medical examiner? 27. Manner of Death

> 4 Homicide 29a. Certifier

1 Yes 2 No

29b. Signature and title of certifie

31. Date filed (Month, Day

1 Natural

2 Accident

3 Suicide

IF FEMALE

6 □Could not be determined

5 Pending investigation

Hospital:

28a. Date of Injury (Month, Day, Year) 28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

2010

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

umberland

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

003328

State Registrar

17

Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

10678

	-	1 - State Registrar				Ce	rtificate of I	Death		Reg. N	0.		
	/	1. Decedent's Name (First, Mid	dle, Last))					2. Date of Dea	ath		3. Time	of Death
nysicia: Medic				JAMES	FRAN	CIS	GRIMES		Month March		ay Year L8 2010	5:1	O AM
xamin		4a. Facility Name (if not instituti	on, <i>give</i> s	treet and numi	ber)		4b. City, Town, c	r Location of Death		40	c. County of Dea	ath	
		Frederick Me	mori	al Hosp	oital		Frede	rick			Frederi	ck	
neral		5. Social Security Number	6. Sex	K M 2 □ F	7. Age (In <i>yr</i> s. I: 57		If Under 1 Year Months Days		8. Date of Birt	th v. Year)	9. Bi	rthplace (Stat	
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at at	ř	10a. State 10b. Coun	ty		10c. Cit	y, Town or Lo	ocation				-	10d. Inside	City Limit
a-t s	octo	Maryland Fred	erick	.c		ederi							Yes 2 🗆 N
or 28	Dir	10e. Street and Number					10f. Zip Code			10a C	itizen of What C		100 2
Important: If item 27 is marked other than "natural", or items 23a or 22a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ral	406 N. Bentz	Stre	eet			2170	1			USA	outility :	
ems r mu	Funeral Director	11, Marital Status		12. Was Deced			Was Decedent of H	lispanic Origin? (Spe	cify Yes or No-		14. Race - Am	erican Indian	
P in		1 ☐ Never Married 2 🛣 M	larried	Armed Ford 1 ☐ Yes	ces? 2 🔯 No		If Yes, specify Cub.	an, Mexican, Puerto I	Rican, etc.)		Black, Whi	te, etc.	
Exa	Completed by	3 🗌 Widowed 4 🗌 Divorc	ed	If Yes, Give Year or Dat			1 ☐ Yes ŽŽ No	Specify:			Specify: W	hite	
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or us	Physician,	23b. Was decedent pregnant in the past 12 months?	-	1 Live B	irth 2 Feta	ideath 3	Ectopic pregnand Other (specify)	СУ			23d. Date of de Month	elivery Day	Year
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Physician/ 2010 5:15 P M Edna A. Goldberg Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery **Examiner** Shady Grove Adventist Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 ₹ F New Jersey Davs Hours Min. 85 Director 150-12-8637 08/16/1924 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville MD Montgomery 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20850 701 King Farm Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ige 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.

It if item 27 is marked other than "natural", or other traumatic event, the Medical Examin by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary "unknown" ၉ Samuel Adler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15104 Columbine Way Rockville, MD 20853 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Daniel J. Goldberg / Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Riverside Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 X Removal from State 03/22/2010 Saddle Brook, NJ 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Family ansky-Goldberg Memorial Chapel M00910 1170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition minutes Pnysician/ Acute Respiratory Failure Medical resulting in death) Due to (or as a consequence of): Examiner 5 years Pulmonary Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

The Funeral Circector: Atten this certificate has been signed by the attending physician and moleted filled in by the funeral director, page 2 should be detached for use as the burial-transit 10 years Cause (Disease or iinjury that initiated events resulting in death) Last Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 X No Pregnant at time of death Month Dav Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes 2 X No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🗓 No 1 Inpatient 2 X ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 X Natural 5 Pending work' 1 Tes 2 🗌 No 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2

To the I

complex 29b. Signature and title March 20,2010 30 pleted cause of death (Item 23a) (Type, Print) 9901 Medical Conter Deir Pahollet

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Of Registrar	Cer	artment of H tificate of D			giene Reg. No.	010	10680
Physician		n/	1. Decedent's Name (First, Middle, Last)			2. Date of Dea	Day	Year	3. Time of Death	
Medica Examine		al	Dewanna Joann Gilbert 4a. Facility Name (If not institution, give street and numb	4b. City, Town, or Location of Death				3 2010 11:10 AM 4c. County of Death		
	LAdiiiii	CI	Union Hospital of Cecil	Elkton			40.00	Cecil		
	Funeral			. Age (In yrs. last birthday)	If Under 1 Year Months Days			h , Yearl	9. Birthplace (State or Foreign Country Elkton	
	Director		216-66-5905 Usual Residence of Decedent	33 Yrs.			Sept.	18,195	6 Mar	yland
	and show	al Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
	Mary 28a-f otifie		Maryland Cecil	n				1 ☐ Yes 2 X No		
	th the 3a or t be n		10e. Street and Number		10f. Zip Code				of What Cou	
036	ath wi	nue	441 Bouchelle Road 11. Marital Status 12. Was Deced	ent Ever in U.S. 13. V	2192		cify Yes or No-		Race - Americ	
	s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	1 ★ Armed Ford 1	2 X_X No	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2XXNo		Rican, etc.)		Black, White,	
<u>5</u>	72 hou		15. Decedent's Education (Specify only highest grade completed)	i (Give I	dent's Usual Occupa kind of work done d	ation uring most of worki	ng	16b. Kind	of Business In	dustry
7	vithin jene. er than		Elementary/Seconday (0-12) College (1-4		life. DO NOT use retired) Line Leader			Wholesale		
Maryland	d be filed v Aental Hyg irked othe itic event,		17. Father's Name (First, Middle, Last) Lawrence Gilbert	•	18. Mother's Name (First, Middle, Maiden Surname) Maudie Nunley				name)	
	of and 2 should be file of Health and Mental H fitem 27 is marked o r other traumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 441 Bouchelle Road, Elkton, Maryland 21921							
Baltimore,	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from 5	20b. Place of Dispo cemeters, cren North Eas Methodist	sition (Name of natory or other place	Marc			ion - City or To	
Ħ	permit. Page Department Important: I any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fundant Service Licenter		Cemetery . Name and Addres					Maryland
B	permit. Departr Imports any inji		Okulle							y1and21901
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Division of Vital Records,							24a. Was a autop	rmed?	death?	psy findings available impletion of cause of
<u>a</u>			25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 1 Yes 2 No No No No No No No							
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	To the Conju	~	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							
			I ancee No. M.		1004	-823		9/2	25/10	
			30. Name and address of person who completed cause JUI CHIH HSU Mb	223 West		ST E	16tor	MJ	21	921
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				Harrison Comment						

Registrar
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RIVERSIDE

SALISBURY ME

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			1 - For State Registrar	State of Maryland		artment of He		nd Mental	Hygien		10682
	Dhynini		1. Decedent's Name (First, Middle, Last)					2. Date of		ay Yeer	3. Time of Death
,	Physicia /Medic		Mary Frances Go					Marcl		3 2010	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or I		Death		c. County of Dea	
	Funeral	-	Salisbury Rehab 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)		If Under 2	4 Hrs. B. Date o	6 Righ	LCOMICO 9. Bir	thplace (State or Foreign
Ū.	Director		214-26-9060	^{]M 2} X∫F 81	Yrs.	Months Days	Hours	Min. (Month	, Day, Yea 3 – 192	8 Vir	ginia
	pu s		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation					10d. Inside City Limits
	Aaryia I eho	o	,								1 ☐ Yes 2 ▼No
	28a-	Director	VA Northum 10e. Street and Number	berland Reed	17111	e 10f. Zip Code			10g. C	itizen of What C	ountry?
	death with the Marylan ne 23s or 28s-f ehow must be notified at	ai Di	509 Buzzard Poi	nt Road		22539			US	: A	
	eme ?	Funerai		12. Was Decedent Ever in U.S Amed Forces?	. 13. V	Was Decedent of His f Yes, specify Cuban	spanic Orig	in? (Specify Yes of Puerto Rican, etc.		14. Race - Ame Black, Whi	
9	72 hours after death with the Maryland naturel; or iteme 23e or 28e-f ehow dical Examitien must be motified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ፟፟፟፟፟ No If Yes, Give Year or Dates:		I□Yes 2∑ No				Specify: Wh	
215-0036	ture!		15. Decedent's Edu		16a. Deced	ient's Usual Occupa	tion		16b.	Kind of Business	/Industry
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2	filed within Hygiene. other than " ent, the Me	Completed	12	Concept (1 to to t)	Tell					nking	
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<u>Z</u>	should nd Mer marke	2	Irving M. Lewis 19a. Informant's Name/Relationship (Ty	ene Print)	10h Mailin	ng Address (Street a		Bryant		or Town State	Zin Code)
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ē,	s 1 end of Heelt item 2 other		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other place	DI	Date		Location - City or	
Ē	nit. Pages bartment of cortant: if it injury or o		1 🎇 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	iemovai irom State		Cemeter	1	-6-2010	Ree	dville	AV.
Baltimore,	permit. Page Department (Important: if any injury or		21. Signature of Funt al Service Linux		B B	Name and Address	s of Facility	917 W.	Isab	ella S	t
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Box	death certifica e attending ph d for use as ti	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar		T				23d. Date of de	elivery
		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			-	Month	Day Year
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ecords,	law requires thet the as been signed by th 2 should be deteche	ρ	Part II. Other significant conditions cor	nthouting to death but not resu	ting in the ui	nderlying cause give	n in Part I.		Did tobacci 1 ☐ Yes		to the cause of death? robably 4 Unknown
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Vital	yelcien: Th	Be	25. Was case referred to medical examiner?					of Death (Check of	nly one)		
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Division	Attending or death. ector: After by the funer	ifica	3 Suicide 6 Could not be	28e. Place of Injury - Al hor building, etc. (Specify,	ne, farm, str			28f. Locat			Rural Route Number,
	rs afte	Certification:	4 Nornicide	building, etc. (Specify,				City	r Town, Sta	HΘ)	
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	Medical	29a. Certifier 1 ☐ Certifying Phy: (Check only one) 2 ☐ Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	rledge, death on and/or in	n occurred at the tim vestigation, in my op	e, date and pinion, deat	d place, and due to h occurred at the t	the cause ime, date a	(s) and manner a and place, and du	as stated. le to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License	number	D	29d. [Date signed (Mor	nth, Day, Year)
	la c		1////	Chan		02	15	4)	13	24/	
1	7 Dr		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)	Λ	. Sulv.	Lin.	NID :	1 804
10	Sta	te	31. Date filed (Morth Dam Vaar)	32. Jegistrar's Signat	J. J.	1 - i Y) C	THUR	CHISI	my		70
	Registr	ar	牌幣 24 2	010 Denoura	1. 4	FRENCH					

			1- State of Maryland / E	-	artment of F rtificate of I		Mental F	lygier Reg. N	001	0 10683
	Physici	an	Decedent's Name (First, Middle, Last) RAYMOND MATTHEW GARNER				2. Date of	Death	8,2010	3. Time of Death 6:50A M
	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea		-	c. County of De	
a di	- Adding		FT. WASHINGTON REHAB CENTER			SHINGTO		P		GEORGES
	Funeral Director		213 22-0007 A 00	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date of (Month, 8 – 1 (Birth Day, Yea 5 – 19	23 MD	rthplace (State or Foreign Country)
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Lo	cation					10d. Inside City Limits
	Maryl a-f sho	żoż	MD. PRINCE GEORGES	FT	.WASHING	GTON				1 XYes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Code				Citizen of What C	Country?
	s 23a	Funeral	12021 LIVINGSTON ROAD 11. Marital Status 12. Was Decedent Ever in U.S.	12 1	2074		Specify Vos or		S.A.	navioan Indian
336	s filed within 72 hours after death with the Maryland II hygiene. other than "natural", or items 23a or 28a-f show yent, the Mcdical Experies must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces?		Vas Decedent of H f Yes, specify Cuba I □Yes 2 🟋No	Specify:	rto Rican, etc.)	NO-	Black, Wh	ite, etc.
15-0036	72 hou natura	eted	15. Decedent's Education 16a. (Specify only highest grade completed)	Deced (Give	ient's Usual Occup	ation	orkina	16b.	Kind of Busines	s/Industry
2	filed within Hygiene. other than "ent, the Mes	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 10th		kind of work done of NOT use retired RPENTER					D BUILDERS
and	I be file antal H ed oth	Be	17. Father's Name (First, Middle, Last) THOMAS ADRIAN GARNER			18. Mother's Na				COE
Maryland 21	should and Me mark mark	유		. Mailir	g Address (Street				LA INS	
	and 2 ealth a n 27 Is ier trai		LAURIE GARNER-DAUGHTER 29	79	THOMAS	RD. E	RYANS	ROA	D,MD.	20616
Baltimore,	Pages 1 an nent of Heal ant: If item 2 ary or other		20a. Method of Disposition 20b. Place of cemeter Burial 2 T Cremation 3 Removal from State TROPOL Donation 5 Other (Specify)		sition (Name of natory or other plac AN CREMA	ATORY 4	Date -2-10	- 1	EX. VA	
Balt	permit. Pag Departmen Important: any injury o	Į.	21. Signature of Funeral Service Licensee M00479	/ I	Name and Address RAYMOND	FUNERA				=
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Due to (or is a consequence of the co	not ente	er the mode of dyin	MARYI , such as cardi	ac or respirator	y arrest,		Approximate Interval Between Obsetvand Death
,09/80	ifficate be executed by g physician and ss the burial-transit can	edical Examiner	Sequentially list conditions, if any, is adding to humaniate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Lue to (or as a consequence of the consequ	In 2	s up herre	hb.	au de	en N	elif	57
O. Box 6	death ceri e attendin id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnanc Other <i>(sp</i> ec <i>ify)</i>	у		-	23d. Date of d Month	elivery Day Year
ds, P	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in	the ur	nderlying cause give	en in Part I.				to the cause of death? Probably 4 ☐ Unknown
ecords	law req as beer 2 shou	Completed					24a. W		24b. Were a	autopsy findings available
r	The ate h page	Som					at pe 1 □ Ye	itopsy erformed? s 2 1	death?	completion of cause of
VITAI	ding Physician: The law h. After this certificate has t funeral director, page 2 s	Be (25. Was case referred to medical examiner?		Oth	26. Place of De	eath (Check on	ly one)		
ō	그 일을 그	To	1 Inpatient 2 ER/Ou	tpatien	t 3 🗆 DOA Othe	4 Let Nursing			6 ☐ Other (Sp jury occurred	pecify)
0	ath. r: Afte	atior		njury	Work	(? Yes 2 □ No			,a., 0000	
DIVISION	To the Hospital or Attending P. within 24 hours after death. To the Funeral Director. After the completely filled in by the funeral process.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, stre	eet, factory, office		28f. Location City or	n <i>(Str</i> eet Town, Sta	and Number or I ate)	Rural Route Number,
	ne Hospit n 24 hour ne Funera pletely fill	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	, death	occurred at the tirvestigation, in my o	me, date and pla pinion, death oc	ce, and due to	the cause ne, date a	e(s) and manner and place, and di	as stated. ue to the cause(s)
	To the To the comp	Ĭ	29b. Signature and title of certifier		29c. License	e number		29d. [Date signed (Mor	nth, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a)	/Tvnn	Print) 0	- 645	/)	, (75,50	1,10
			LAMI N. Already 7700	, Ol	d Syan	ch Ave	Clin	lon	- W 1	120735
	Sta	ta	31. Date filed (Month, Day, Year) 32. Registrar's Signature				<			

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 30. 2010 6:00 Helen Louise Goldey Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick <u>Country Meadows of Frederick</u> Frederick 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 97 New York Director 057-07-7152 912 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5955 Quinn Orchard Road 21704 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 X Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Canfora Ida Gaibais 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Lodwig / Daughter 10566 Edwardian Lane, New Market, Maryland 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apri $\Gamma^{ ext{at}}$ 5. 1 🕅 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 2010 Queens, New York 21. Signature of Funeral Service Licensee Keeney & Bastord 106 East Church l PA Funeral Home Street, Frederick, Maryland 21701 MO1473 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Nivarder Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and I for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregna
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy performed Yes 2 1 Yes within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Retirement Community 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 YOther (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

32. Registrare Signature

30. Name and address of person who completed cause of geath (Item 23a) (Type, Print)

M.D.

William H. Convey.

DHMH 17 Rev 7/2009

195 Thomas Johnson Drive, Frederick, Maryland 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .^{Day}201<u>0</u> Physician/ March 18, Penny Lynne Hanshew 1:06 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7920 Worman's Mill Road Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Min. 1 □ M 2 🖾 F Months Hours 0c 40nth, 30, Year 963 Maryland Director 212-68-8533 46 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland Frederick Frederick 1 🛛 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7920 Worman's Mill Road 21701 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married δ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: Specify: White 3 ☐ Widowed 4 X Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Patricia A. Noell David C. Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7924 Worman's Mill Rd., Frederick, MD 21701 Patricia A. Cook / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 20, permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🗋 Burial 2 🛛 Cremation 3 🗖 Removal from State Resthaven Crematory 4 Donation 2010 Frederick, Maryland 21. Signatu Funeral S Resthaven Funeral Services, Skkot Cody P.A 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part Enter the dis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shook, or heart fail Interval Between Onset and Death List only one cause on each line. Immediate Cause (Findisease or condition resulting in death) Physician Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 4 Pregnant g Unknown Pregnant at time of death Other (specify) completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Plassidence} \) 6 \(\text{Other (Specify,} \) Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA ည 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature and title of certifier

within 2 To the I

10

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Joan E. Hicks 2010 22, 10:15AM March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Chestertown Nursing & Rehabilitation Kent Chestertown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 Country) Massachusetts Davs Hours Min 9/1/1924 Director 85 029-14-6780 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mantal Hyglene.
Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12347 Woods Rd. 21678 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Language Teacher Education/High_School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John F. Mahoney Carol W. Murphy and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, PrInt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Landskroener/daughter 12347 Woods Rd., Worton, MD 21678 permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other t 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) South Dartmouth Cem. 3/26/2010 Darmouth, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 Kick D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ railine To disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Pregnant at time of death 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, The law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural Division 1 Yes Investigation 6 Could not be Accident 24 hours after deat Funeral Director: Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ARRABAL TR-M-D

31. Date filed (Month, Day, Year)

223 Hoch Street, Copertestorm Hed 21626

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ $2^{\frac{1}{9}}$ P_{M} Regina 4:10 Elizabeth Hargett March 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Golden Living Center Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Maryland 1 M 2 X F Hours Min 79 **Director** Oct. 213-24-9349 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Maryland Frederick Mt. Airy 1 🗌 Yes 2 🖵 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12415 Catoctin View Drive 21771 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Agent/Broker Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irvin Franklin Hill Crouse, Sr. Elsie Elizabeth Painter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Hargett, Sr., Husband 12415 Catoctin View Dr., Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Mount Olivet Cemetery April 3, 2010 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu ²² Name and Address of Facility Keeney and Basford PA Funeral Home FunerahService Linensee M00255 106 Fast Church St. Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death ementia Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iiniu) and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death signed by the a 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▶ No 24a. Was an page 2 autopsy this certificate 25. Was case referred to medical Be funeral director, 26. Place of Death (Check only one examiner? Hospital: Other: မ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After injury 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 6
Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Chec Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only (ne) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D 0062223 March 30, 2010

DHMH 17 Rev 7/2009 GI

State

Registrar

32. Registrar's Signature

KRAYEEN B. LARUM MD

APKU

31. Date filed (Month, Day, Year)

Toress of person who completed cause of death (Item 23a) (Type, Print) SUITE # 135, PREDEAICE, MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10c-g per DVR G902 4///10 dR
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 0688 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MADGE SHOCKEY JONES 27, 2010 P^{M} March 2:25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FROSTBURG VILLAGE NURSING HOME ALLEGANY FROSTBURG If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/27/1921 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 236-20-1187 1 □ M 2 😿 F 89 PHILIPPI, WV Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Frostburg ALLEGANY MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21532 1 Kaylor Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11, Marital Status Black, White, etc. filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: WHITE \$ 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RETAIL 12 HOMEMAKER AND SECRETARY alth and Mental Hygir 27 is marked other I r traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be HENRY J. SHOCKEY VESTA LEE BURNER SHOCKEY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. 4716 TROTTING LANE, ALEXANDRIA, VA 22003 DOUGLAS H. JONES - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/01/2010 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) SUNSET MRMORIAL PARK 22. Name and Address of Facility HAFER FUNERAL SERVICE P.A. 21. Signature of Funeral Service Licensee John Ja en 1302 NATIONAL HWY. LAVALE, MD _ 21502 23a. P. rt1. Enter the disc. s., or complication; that caused an death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final E **Physician** MENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 □Yes 2 ŪNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐No Hospital or Attending Physician: 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DR. HARJIT S. SIDHU, M.D.,

31. Date filed (Month, Day,

D 26907

925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502

MARCH 30 ZUIO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1 = For State Registrar		Certificate of	Death	Reg.	No.	
Physician /Medical	1. Decedent's Name (First, Middle, Las	Name of the latest of the late	phnson		2. Date of Death Month	Day Year	3. Time of Death
Examiner		112322	oad 4b. City, Town, o	r Location of Death		4c. County of Dea	th
Funeral Director	214-52-0940 6.S	ex 7. Age (In yrs. I. 60	ast birthday) If Under 1 Year Monihs Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 7-28-19	9. Bir	thplace (State or Foreign
aryland thow	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
with the Mar a or 28s-1 o be notified	MD Somers 10e. Street and Number	et Pri	ncess Anne 10f. Zip Code		10g.	Citizen of What Co	1 ☐ Yes 2 ☐ No X
23a o 23a o ust be	11485 Drawbrid	ge Road	21853		U.	S.A.	
be filed within 72 hours after death with the Maryland and Hylylene. d other than "natural", or items 23s or 28s-f show event, the Medical Examinar must be notified at event, the Medical Examinar must be notified at Be Completed by Funeral Director.	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hif Yes, specify Cubi		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	te, elc.
led within 72 hours g ygiene. her than "naturel", o nt, the Medical Exan Completed by	15. Decedent's Ec (Specify only highest gra	de completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Housekeeper	durina most of work	ring	o. Kind of Business	/Industry
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should be filed within and Mental Hygiene. I marked other than amatic event, tha M. To Be Comp	Wheatley Ward			Vivian	Johnson		
nd 2 stranger trans	19a. Informant's Name/Relationship (t-Johnson/	19b. Mailing Address (Street	ridge R	al Route Number, Ci Oad, Pri	ncess A	nne, MD
Pages 1 ar nent of Hea ant: If Item ary or othe	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	riemoval from State	ace of Disposition (Name of emetery, crematory or other place hnson Family	- 13 - 70	-2010	Location - City or rion St	Town, State ation, MD
permit. Pages Department of Important: If it eny injury or once.	21. Signature of Funeral Service Licen	See A	22. Name and Addre	- C-22	7 W. Isa	bella S	t.
	23a. Part1. Ent the dise se, or com shock, or heart fail. e. List only	plication, that caused the death	Funeral H		Lisbury, or respiratory arrest,		Approximate Interval Between
hysician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		Lax cancer				Onset and Death
tilicate be executed by physicien and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)	·				
e ettending d for use a: Cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, oulcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant al time of de 9 □ Unknown	death 3 Ectopic pregnancy			23d. Date of de Month	livery Day Year
be be	Part II. Other significant conditions of	ontributing to death but not resu	lting in the underlying cause giv	en in Part I.	23e. Did tobaco		o the cause of death?
ate has page 2					24a. Was an autopsy performed	dealh?	utopsy findings availab completion of cause of 2 No
V 0 0	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpalient 2 ☐ E	ER/Outpatient 3☐ DOA Oth		h <i>Check only one</i> ome 5 Residence	e 6 Wother (Spe	city Home. H
After fune	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 28c. Injur Wor 1		28d. Describe how in		
	3 Suicide 6 Could not be determined	building, etc. (Specify,			28f. Location (Stree City or Town, St	tate)	
o the Hospital or thin 24 hours after the Funerel Dir impletely filled in Medical Cert	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knov iner: On the basis of examinati and manner stated.	vledge, death occurred at the tir ion and/or investigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date	e(s) and manner a and place, and du	s stated. a to the cause(s)
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a.	30 Name and address of person who			0 11	Ci I	100 2	2010 Mo 21801
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0204 M Gloria Ann Jones March 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Nov 28, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. Country) Maryland 214-28-6111 Director 78 Nov. Usual Residence of Decedent f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director or 28a-f sh notified 1 🗌 Yes 2 🏋 No Washington Smithsburg Maryland 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o Funeral 22048 Jefferson Blvd 21783 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. δ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Divorced 4 Divorced Year or Dates hould be filed within 72 hours and Mental Hygiene. s marked other than "natura umatic event, the Medical E Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Auto Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental rtant: If item 27 is marked o jury or other traumatic eve ည Howard R. Kendall, Sr. Charlotte K. Yowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22048 Jefferson Blvd. Smithsburg, Maryland 21783 Alvey O. Jones (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 2 Cremation 3 Removal from State March Important: I Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 31, 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final dis PL Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Protote Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 Unknown the detached þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? Benuti 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, It is a completed filled in by the funeral director, It is a completed filled in by the funeral director, It is a completed filled in by the funeral director, It is a completed filled in by the funeral director, It is a completed filled in by the funeral director, It is a completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Anatural wark' 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) not mo D (80 (9 march 29 2010

State Registrar 345

MILLIT MAGRESTOWN

Carles

mo 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VASANT DATION

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Item 21 per F D. 03/24/2010 Carroll Co., wil (per dhb @ DVR)

For For State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 0716 Ам <u>Franklin J.Kress</u> Mar. 20 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester

9. Birthplace (State or Foreign Country) Social Security Number 176-32-1869 6. Sex 1 № 2 □ F 7. Age (In yrs. last birthday). 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. **Funeral** Min. Months Days Hours Director PΑ Feb.6,1937 Usual Residence of Decedent the Maryland 10c. City, Town or Location Littlestown 10a State show 10b. County Adams 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shorevent, the Medical Evariant in ust be redified at 1 dYes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a amy injury or other traumatic event, the Medical Evantions in ust anone. 114 Maple Avenue Funeral 17340 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. I ∏Yes 2 ∏No If Yes, Give 1954 – 57 Year or Dates 1954 – 57 1 Never Married 2 Married White 1 □Yes 2 □ No Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Industrial Caterer Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Kress Helen Stavely ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Kress -Wife 114 Maple Ave.Littlestown, PA17340 Baltimore, 3/27 ate 2010 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Aloysius Catholic Cemetery Littlestown, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 17340 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Little's FH 34 Maple Ave.Littlestown, PA Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYDEARDIAL INFIRCTION MMEYIATE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, HYPERCHOLESTEROL F.MIA, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABLES 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1∐Yes 2.2TNo of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 224 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOROTHY 203 SMON ST. SHOW HILL MD. 20863 NID HOLZWORTH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 24 Registrar

TaD0716

DeD 3/20/2016

PANKlin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Registrar AMEND#26perMD, 3/24/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 1:00 a.M Olha M. Kozak Medical March 2010 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 9014 Sudbury Road Silver Spring 5. Social Security Numbe 9. Birthplace (State or Foreign Country) Ukraine If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 1 □ M 2 🗱 F Months Days 0871271914 Director 361-26-5142 95 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 5029 Green Mountain Circle, 21044 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, o. þ 1 Never Married 2 Married Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Specify. Completed 3 X Widowed 4 □ Divorced White. Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 4 Secr<u>etary</u> Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stepan Harabach Maria Boryslawska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrian S. Kozak - Son 10767 Kinloch Road, Silver Spring, Maryland 20903 Baftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery | 03/16/2010 | Suitland, Maryland ignature of Funeral S rvive Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between VASOUKCE Immediate Cause (Final set and Death ∓hysiciaπ/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner physician and the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician by Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown been signed by the a should be detached f 9 🗌 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 € No Division of Vital To the Hospital or Attending Physician: npleted filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one Friend's Home Hospital 1 Yes 2 🖷 No 1 Inpatient 2 Inpatient 3 Inpotent 2 Inpatient 3 Inpotential 2 Inpatient 3 Inpotential 2 Inpatient 3 I after death. Director: After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 W Natural injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State 24 hours Medical 🙅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year William Gustav Kapp March 28 2010 0450 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Cecil Elkton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. 1 X M 2 □ F Director 218-28-6514 3, 1932 Maryland June Usual Residence of Decedent 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Madical Examinar a ust be notified at Director 1 ☐ Yes 2 X No Ceci1 Maryland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23an any injury or other traumatic event. 1195 Appleton Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify ģ Specify: 3 ♥ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Pigments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William T. Kapp Rosalie S. Szuleski ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allan S. Kapp/Son 1209 Appleton Road, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Elkton, MD 21. Signature of Funeral Service Licenses Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line.) Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any lating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No 5 Other (specify) the detached 9 Unknown þ ins certificate has been signed director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital 1 Maryes 2 □ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 K No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one. within 2 To the I 29b. Signature and 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State	State of	Marylar	•				and M	lental Hy	giene			100	- 0 !
			Registrar 1. Decedent's Name (First, Middle,	I aet)		Cer	tificate	of L	eath		2. Date of Dea	Reg. No	o./ U	LU		194
	Physicia Medio		Flora A. Ke	essel							Month 03	atin O	a y	Year	3. Time of 222	
	Examin	er	4a. Facility Name (if not institution, WMHS-Regional	-		e.R			Location of ECION			40	: County o	of Death	4	
	Funeral Director		5. Social Security Number 292-20-0310	6. Sex 1 □ M 2 💢 F	Age (In yrs. i	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Sept	h v. Year) 20,1	916	Count	lace (State or ry) celdale	
and	show	or	Usual Residence of Decedent 10a, State 10b. County		10c. Cit	ty, Town or Lo	cation								0d. Inside Cit	
e Maryl	28a-f notified	Director		neral		Key	ser								1 X Yes	2 🗆 No
with the	23a or	eral [10e. Street and Number 1380 Terri	Street			10f. Zip (726			10g. Ci	itizen of W	hat Count	try?	
death	items ner mu	Funeral	11. Marital Status	12. Was Decede		S. 13. \	Vas Decede f Yes, specif	ent of His	spanic Origi	in? (Spe	cify Yes or No- Rican, etc.)		14. Race			
21215-0036 within 72 hours after death with the Maryland	of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Mcdical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Marri 3 🎇 Widowed 4 ☐ Divorced	ied 1 Tes 2 If Yes, Give Year or Date		1	☐ Yes 2				, ,		Specify:		ite	
Maryland 21215-0036 2 should be filed within 72 hours after	n "natu A dical	Completed	(Specify only higher	t's Education st grade completed)			lent's Usual kind of work O NOT use i	done d	ation luring most	of workir	ng	16b. K	Kind of Bus	iness Ind	ustry	
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land be filed	ental Hy ked oth c even	To Be	17. Father's Name (First, Middle, La George T. Amt	,							(First, Middle, V. Bos		Surname)			
Maryl 2 should	and Me is marl aumati		19a. Informant's Name/Relationsh			19b. Mailir	ng Address ((Street a			Route Number		r Town, Sta	ate, Zip C	ode)	
e, M and 2 s	Health em 27 ther tra		Thomas E. Amto	wer/Nepher		Rt	1,		245-		Burling					
altimore, mit. Page 1 and	nent of unt: If it ny or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		tate (cemetery, cren	natory or oth	her place	. A	pril 201			ocation - 0	·		
Balti permit.	Department of Health and Menta Important: If item 27 is marked any injury or other traumatic eronce.		21. Signature of Eugeral Service L	censee		22	. Name and	Addres	s of Facility	S	mith Fu	ner	al Ho	me		
			23a. Part 1. Enter the disease, or	complications that car	used the deat		35 S. er the mode				_		WV 2		Approximate	
	ysician/		shock, or heart failure. List of Immediate Cause (Final disease or condition		rune.	y A	tery	l)15 ca	ne					Interval Betw Onset a	
	Medical caminer		resulting in death)	Due to (or	as a conse	nce of):	V								/	
ď	tis.	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseq	uence of):										
execute	physician and the burial-transit	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):								\dashv		
60 ate be	ohysicia the bur	edical	•	d										_		
certific	ending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna	ancy al death 3 [] F -1i						23d. Date	of delive	ry	
Box 68	been signed by the attending should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		nt at time of		Other (spe		у	-			Mont	th I	Day Ye	ear
P.O.	gned by se detad	by Ph	Part II. Other significant condition	ns contributing to dea	th but not res	sulting in the u	nderlying ca	ause giv	en in Part I.		23e. Did to				e cause of de	
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Seco	certificate has been rector, page 2 should	Completed											pr de		npletion of ca	
tal F	is certifica director, p	Be C	25. Was case referred to medical examiner?					26. Pla	ace of Death	n (Check		2)211	<u> </u>			
f VI	this o	은	1 Yes 2 No	Hospital:	-	ER/Outpatier			4		me 5 Resid					
On o	er death. rector. After this by the funeral di	ficate	Natural 5 Pending	g (Month, ation	Day, Year)	injury	M 28	c. Injury work1	rat ? Yes 2 □ t		8d. Describe h	ow injur	y occurred	l		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed	Directo	Certificate;	3 Suicide 6 Could r 4 Homicide determi	28e. Place of	Injury - At ho , etc. <i>(Specif</i>)	ome, farm, stre	et, factory,	office		2	28f. Location (S City or Tow			or Rural I	Route Numbe	ır,
Hospita	within 24 hours aft To the Funeral Dis completed filled in	Medical	(Check 2 L Medical Ex	Physician: To the bes xaminer: On the basis	of examinatio	n and/or invest	igation, in m	iy opinioi	n, death occ	curred at	the time, date a	nd place	e, and due t	o the cau	se(s) and man	ner stated.
To the	vithin 2 Fo the I	Me	only one) 3 Certifying 29b. Signature and title of certifer	Nurse Practioner: To	the best of m	y knowledge, o	leath occurre	ed at the	number	and place	e, and due to the	e cause(s) and man	ner as sta	ted.	
			• 4	melso,				Do	332	80		M	mich	2.	1,201	0
			30. Name and address of person w Sunil Gupta, r	no completed cause	of death (Item	n 23a) (Type, P + Aven	ue Su	üte	201	Cu	mberla	nd,	mar	ylar	nd 219	502
	Stat Registra	te	31. Date filed (Month Day, Year)	2010 3 Reg	istrar's Signa	iture	and I									

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 19, Day 2010 Year Ermine Layer Norma 0010 hr's Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Northampton Manor Nursing Center Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Aug 11, **Funeral** 9. Birthplace (State or Foreign Days Hours Min Months Day, Director 212-24-7430 82 Maryland Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Maryland Frederick Adamstown 1 🗌 Yes 2 🏝 No 10e. Street and Number 10g. Citizen of What Country? USA 10f. Zip Code Funeral 3019 Flint Hill Road 21710 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2XXNo Specify: "natural". Specify: black 3 ☑ Widowed 4 □ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hyglene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fulton Weedon Anna Johnson permit, Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Pannell - daughter 3319 Flint Hill Road, Adamstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Resthaven Memorial 3-24-2010 Frederick, Maryland 4 ☐ Denation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. riset and Death Immediate Cause (Final Physician/ STROKE Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to himbediate cause. Enter Underlying Cause (Disease or linjury that initiated as or the Examine Due to (or de a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has page 2 autopsy performed? Yes 2 No death? Yes 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: And the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pleted (Check 3 Certifying Nurse only one) 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) D4309 3-19-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOU Home Are Fordenle MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

arker

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201<u>0</u> Physician/ Madaline T. Litteral March 22, 8:35 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friends Nursing Home Sandy Spring Montgomery 8. Date of Birth (Month, Day Y Mar. 30, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 19<u>17</u> 1 □ M 2 🗚 F Days Min. Months Hours 400-18-6850 Ohio **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funera 11412 Kenton Place USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔼 No "natural", or within 72 hours after 1 Yes 2 No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Store Bakery Manager Grocery Store permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Winton Buckley Stella Snider 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 270 Oak Lane, Reedville, VA Fleming Litteral / Son 22539 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ò 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Juneral Service Licen 22. Name and Address of Facility 22. Name and Address of Facility Francis J. Collins Funeral Home, 500 University Blvd. W., Silver 500 University Blvd. MD 20901 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Coronary Artery Disease 5 Yr. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): executed Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 No ed by the a detached f g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed a 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown Completed Lymphoma page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Hypertension autopsy performe Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital:

68760 Box (P.O. Records. director of Vital this Division

21215-0036

Baltimore, Maryland

Hospital or Attending Physician: The To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director.

2

Certificate:

Medical

31. Date filed (Month, Day, Year) MAR 2 4 2010 State Registrar

2 🔀 No

5 Pending

Investigation 6 Could not be

determined

27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide

29a. Certifier

(Check

only one

29b. Signature and title of certifier

Arthur Schoengold, MD 18111 Prince Philip Drive, T-10, Olney, MD 20832 72. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

28a. Date of injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at

1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D18726

29c. License number

work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

March 23, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 Year March 24, Amelia A. Leichel 5:30P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chestertown Nursing & Rehabilitation Kent Chestertown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 □X Hours 5 / 20 / 1929 160-26-5824 Director 80 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 ¥ Yes 2 □ No Chestertown MD Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 415 Morgnec Road 21620 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Adelbert Leichel Amelia Gertrude Schindel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 20, Still Pond, MD 21667 Charlotta B. Bowie/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Valley Forge Memorial
Gardens 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State any injury 4 Donation 5 Other (Specify) 4/1/10 King of Prussia, PA Signature of Funeral Service Licens 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complic flions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only or Immediate Cause (Final Onset and Death Disease Physician/ Alzheimers disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of). resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 2 9 ☐ Unknown 9 Unknown P.O. signed by t. Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kidney Disease, HTIU, BIPGION DIO Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certificate has been sit completed filled in by the funeral director, page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hx Adonoma & Colon 24a, Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1. Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical ZCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 12010 0050996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tim Chastertown MD 21620 Weil Staddard MD 100 Brown 31. Date filed (Month, Da Regist s Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 20b per FH 4/7/10 G902 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04^{Month} ი^{₽ay} 2010 Medical BERTHA H. LAURIE 0310 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ALLEGANY CUMBERLAND WSTERN MD REGIONAL MEDICAL CENTER . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth Funeral Days 1 - M 2 X Hours Min 11-04-1913 Director 215-20-7370 96 PENNSYLVANTA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No FROSTBURG MD ALLEGANY 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 16900 NATTONAL HWY SW 21532 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: 3 ₩ Widowed 4 Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) HOUSEKEEPING HOUSE KEEPER 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည VIOLET MAE SHORT HOUSE JOHN L. HOUSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAZEL EAGAN NTECE 19919 LONACONING ST., MIDLAND, MD 21542 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory

04-03-2010 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 M Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND. MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOWERS FU FROSTBURG Han FUNERAL HOME, M00547 60 W. MATN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death INTE OBSTRUCTION Priysician/ TINAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Distributes a consequence of if any leading to immediate cause. Enter Underlying physician and the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: . nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No has been signed by the atte e 2 should be detached for Dav Year Pregnant at time of death g Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CONGESTIVE HEART PAILURG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌠 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? s certificate ha director, page 2 2 No Yes 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation the Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completed fi 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number Helly APRIL U3 2010 D26907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 92 Marlit 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

3

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paul Matthael												
Physician Medical Examine		_{Vard Matthaei}				Month E	Day Year	3. Time of Death 2152 hrs				
	4a. Facility Name (if not instituti			4b. City, Town, or	Location of Death	April 2, 2010	4c. County of Deat					
	1519 Brehm Road			Westminste			Carroll					
Funeral Director	5. Social Security Number 227–74–2577	6. Sex 7. Ag	e (In yrs. last birthday	Months Days		Dec 19,	Forei	rthplace (State or g-Washington puntry) DC				
ŕ,	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits				
and show	Maryland Car	roll		We	estminste	er		1 Yes 2 No				
the Maryland a or 28a-f show any tified at once.	10e. Street and Number	1	<u> </u>	10f. Zip Code	04455	10g.	. Citizen of What Cou	•				
rith the 23a of 101 of		.CI. 12. Was Decedent	Ever in U.S. 13	Was Decedent of His	21157	157 USA in? (Specify Yes or No- 14. Race - American Indian,						
or death with or items 23	1 Never Married 2 K	Armed Forces		If Yes, specify Cuban			White, etc.	ican Indian, Black,				
ral", o	3 VVidowed 4 Di	vorced If Yes, Give Year or Dates:	1	Yes 2 No			орвону.	white				
2 hours "natu			durin	dent's Usual Occupat g most of working life.			6b. Kind of Business/	Industry				
5-0036 ed within 72 hour sygiene. other than "natu the Medical Exar	12			lf Employe	ed.	Merchant Seaman						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica			-			s Name (First, Middle, Maiden Surname) aura Johnson						
2121 rould be fi d Mental I s marked tic event,	<i>i</i>		19b. Ma	iling Address (Stree			er, City or Town, State	e, Zip Code)				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Eurograf Director	Jennifer Matth	aei, wife		9 Brehm Ro								
ore, ges lan of Hea If iter	20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal from St	ate Sountatory or			Date 2	20c. Location - City or					
Baltimore, permit. Pages I at Department of He. Important: If ite Mijury or other tr	4 Donation 5 Other S			Crematory 2. Name and Address			Winfield					
Dep Dep I	Justi R. 1	Suton	westmins	oraw Funer ster, MD 2	rai Home 1157							
Physician // // // // // // // // // // // // //		Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each line.										
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Exsanguit						Death				
	Sequentially list conditions,	b Cutting	wound of r	ight arm								
ted Insit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	equence of):									
ecuted and and transit	events resulting in death) Last	Due to (or es a conse	equence of):									
S = 3 .9	X UNPENDED	¬ ———	ine a-b, 2	7 28a-f ne	rm F agn	2 4/13/1	О ТТ					
760, ficate be g physici the buni	IF FEMALE: 23b. Was decedent pregnant in the	23C. II yes, outcom	ne or pregnancy				23d. Date of delivery	/				
Box 6876 c death certificat the attending phy ed for use as the Thysician/M	past 12 months?	4 Pregnant at	time of death 5	Fetal death 3 L Other (Specify)	Ectopic pregnan	icy	M onth [Day Year				
by the at sched for	1 Yes 2 No 9 Uni	Unknown	but not resulting in th	e underlying equee ai	ivon in Port I	23a Did toba	cco use contribute to	the cause of death?				
of Vital Records, P.O. Ing Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detact on: To Be Completed by F.		ions contributing to dead	r but not resulting in th	e dilderlying cause gr	veri in Parti.			pably 4 Unknown				
Records, The law requires ficate has been sig	K1:				•	24a. Was an autopsy		topsy findings available				
Reco						performe 1 Yes 2 ₩	ed? death?					
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical examiner? Hospital: I Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 10 Other										
n of Viding Phys 1. After this funeral di	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b. Time o				sidence 6 🗹 Other vinjury occurred purposeful					
ion (tending eath. tor: Ad the fur	1 Natural 5 Pend 2 Accident Inves	ding (Month, Day, Young ding 4/2/10	9:22 j	om 1 7	on Olaine I		purposeiui vsis acces					
Division ospital or Attending tours after death. neral Director: After filled in by the function: Certification:	3 X Suicide 6 Coul	d not be 28e. Place of Inj	ury - At home, farm, st		ilding, etc. 2	28f. Location (Stree	et and Number or Ru	ral Route Number, City				
	1 29a Cerimer -	hysician: To the best of my	residence				Rd Westmi					
To the Hospital within 24 hours To the Funeral completely filled	(Check only one) 2 Medical Exa	miner: On the basis of exam and manner stated.										
WIL W	29b. Signature and title of certifie			29c. License		1.	9d. Date signed (Mor	nth, Day, Year)				
0	20 Name and address of	— M	ooth (Itam 225)	O.C.N	n. ∟ .		April 3, 2010					
	30. Name and address of person Donna M. Vincenti, MI	D Assistant Medic		11 Penn Street,	Baltimore, MD	21201						
State Registra	31. Date filed (Month, Par Year)	31. Date filed (Month, Par Year) 5 2010 32. Redistrar's Signature B. Sall										
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10-02464 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert McPherson, III State of Maryland / Department of Health and Mental Hygiene 010 10700 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day March 28, 2010 **Medical Examiner** 1841 hrs Robert A. McPherson III 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick Mount Airy 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months Director CountryVirginia 1XM 2 F Yrs 521-02-3192 49 24,1960 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Hygiene. d other than "natural", or items 23a or 28a-f shoi , the Medical Examiner must be notified at once. Maryland within 72 hours after death with the Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ä 4015 Lomar Drive 21771 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No 1 Yes f Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry it. Pages 1 and 2 should be filled within 72 ho trunent of Health and Mental Hygiene.
Tant: If item 27 is marked other than "natt or other traumatic event, the Medical" Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Courier Company Driver 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Robert A. McPherson Jr. Caroline Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline L. McPherson/ Sister 4015 Lomar Drive, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Baltimo permit. Page Department of Important: injury or oth Stauffer Crematory Inc. 3/31/10 Frederick, Maryland Donation 5 Other Specify 22 Name and Address of Facility Stauffer Funeral Homes P.A. 1621 Opossumtown Pike, Frederick, Maryland 21. Signature Funegal Sarica Ico 21702 Part I. Enter the disease, or complication by t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician failure. List only one cause on each ling Retween Onset and /Medical Death Cardiac tam onade Examiner or condition resulting in death) Due to (or as a consequence of): b. hemopericardium Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause c. Rupture of myocardial infarction (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical AMENDED ending physician use as the burial -Y UNPENDED line a-c, PII,27,permE, g902 4/8/10 TT The law requires that the death certificate be Box 68760, IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending p Live birth 3 Ectopic pregnancy Month Year 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached fo Phy P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l þ 1 Yes 2 No 3 Probably 4 V Unknown Atherosclerotic cardiovascular disease Completed Records, this certificate has been I director, page 2 should 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? death? 1 🗸 Yes Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) **Division of Vital** Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other 4 Nursing Home 5 Residence 6 🗸 Other: Scene DOA 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 Yes 2 No the Director; Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) within 24 hours aff To the Funeral Di completely filled in (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 29, 2010 siane 4 30. Name and address of person who impleted cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Matthews Month 03 Physician/ 00 2010 obes Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Westminster Carroll Carroll Hospital Center 9. Birthplace (State or Foreign Social Security Number 183-18-6942 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Min. MD. (Month, Day, Year) 22 1 🛛 M 2 🗆 F 87 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Baltimore White Hall MD 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21161 USA 922 Bernoudy Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. Oxyes 2 No 1945 Yes, Give 1052 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 K Widowed 4 Divorced 1952 Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Baltimore County life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State Highway mechanic 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Founds 2 Robert Matthews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21102 19a. Informant's Name/Relationship (Type, Print) Charlene M. Rhoten, daught 2825 Fridinger Mill Rd., Manchester, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Wiseburg Cemetery 3/20/2010 White Hall, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 934 South Main St., Hampstead, Md. $M0074\overline{1}$ 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hour disease or condition resulting in death) Medical Due to (or as a cons Examiner tone Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Yes 2 No 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 🛮 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Martin

31. Date filed (Month, Day, Year)

MAR 2 2 2010

00

Registrar's Signature

Memoria

Britos-Bray

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20, 2010 Year **Physician** March 6:45 P. Jennie Lee Monroe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly Prince George's Prince George's Hospital Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 0170871921 Wash., D.C. Months 1 □ M 2 □ XF 89 578-38-3767 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ral", or items 23a or 28a-f show Examirer must be nuffied at 1X Yes 2 □ No Director Washington D.C. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20001 U.S.A. 1616 Marion St., N.W. # 118 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a any hijury or other traumatic event, the Medical Examiner rugs 1 once. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Elementary/Secondary (0-12) College (1-4or 5+) Employment Services Clerk 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Mack Peter Lee Adams ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1646 U St., S.E., Washington, D.C. Ruth E. Reid/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 03/30/10 Suitland, Maryland Lincoln Mem. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARRHYTHMIA FATAL CARDIAC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) HYPERTENSION Examiner Sequentially list conditions, Due to (or as a consequence of) ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Puneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 Other (specify) 9 Tilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient ၉ 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY MD. 20785 HOSPITAL DR. SATTARIAN 3001 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 5 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** March 20, 2010 10:38 A M Edith Mitchell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year Min. Months Days Hours 1 ☐ M 2 🗗 F Yrs. 257-32-0240 81 Sept. 16,1928 Georgia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 ☐ No Director Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20018 3298 Ft. Lincoln Drive NE #614 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. If Yes, Give Year or Dates African à 3 X Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamtress Private 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther Hollis Annie Mae Ward 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 14 Buchanan Street NE Washington, DC 20011 Gwendolyn Mitchell/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony 20c. Location - City or Town, State Date 20a. Method of Disposition March 25, 1 Burial 2 □ Cremation 3 □ Removal from State 4☐ Donation 5 ☐ Other (Specify) 2010 Landover, Maryland Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Who 4001 Benning Rd. NE Washington, DC 20019 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIAC FATAL ARRHYTHMIA **Physician** /Medical Due to (or as a consequence of): Examiner HYPERTEN Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed HEART CONGESTIVE sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the burla Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner states within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00065367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR.M. SATTARIAN 3001 CHEVERLY HOSSITAL 31. Date filed (Month, Day, Year, MAR 2 5 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Рм Doris Alma McDowell 2010 1915 Apri1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** E1kton Ceci1 Union Hospital Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Month, Day, 1 □ M 2 🗓 F Months Days Hours Min. Maryland Director 81 220**-**24**-**7625 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ould be filed within 72 hours after death with the do Mental Hygiene. The first Hygiene are stated other than "natural", or items 23a on martic event, the Medical Examiner must be matic event, the Medical Examiner must be. Funeral 1800 Singerly Road 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: Completed White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) In Her Own Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev William Jennings Alma Mattie Poe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is Sharon L. Barker/Daughter 648 Hopkins Mill Road, Quarryville, PA 17566 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Elkton. MD 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, 21021 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RENAL disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** HEART CON GE CTIVE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PERIPHENA WASULAN DUEASE 1 Yes 2 No 3 Probably 4 Unknown icate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? this certificate 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Nnpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29a. Certifier

only one)

29b. Signature and title of certifier

NARAYANA 31. Date filed (Month, Day, Year)

P. V. Naye N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

RAD. V. PULA

3 Registrar's Signature

MARIA

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

000 65733

29d. Date signed (Month, Day, Year)

STREET. IZLKINN, MD

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

126 A E. MGH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Marylar	•	artment of l			lental Hy	gien Reg. No	0010	1 10705
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and the	Examin	ie:	Upper Ch		-		Cente		Bel	Air			Hari	ford
	Funeral		5. Social Security Nu		6. Sex	7. Age (In yrs) If Under 1 Year	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D	rth	9. Bi	rthplace (State or Foreign country)
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Joyce, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a five final Extra internant be mailfed at once.		19a. Informant's Nar	me/Relations	ship (Type. Print)		19b. Mail	ling Address (Stree	t and Num	ber or R ura		-		Zip Code)
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	Sta Registr		JI. Date filed (WORK	AP	2010 R	A SIGN	W A	LA MORNE	S					

DHMH 17 Rev 1/2001

10-02291 Michael Sean McVearry

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State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar		C	ertific	ate of	Death				Reg. No.			
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Funeral	5. Social Security Number	6. Sex	7. Age (In yr	s. last bin	thday)	If Under 1 Ye	$\overline{}$	der 24Hrs.	8. Date of	Birth(MM/	DD/YYYY)	9. Birth	place (State or
Director	215-76-0499	1X M 2 F	50		Yrs.	Months Da	ys Hour	rs Min.	08/3	1/19	59	Foreign Cour	Washington
<i>b</i>	Usual Residence of Decedent		lië. e										D.(1.
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with the se 23a ce noti			cedent Ever in		13. Was	Decedent of Hi	ispanic Or	igin? (Spe	cify Yes or I	No-		- America	an Indian, Black,
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safter iral", o	3 Widowed 4 A Div	orced If Yes, Give Yes	ar		1 🔲	Yes 2 X No	specify	<i>i</i> :			Specify:	Whi	
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S-00 Signal with Signal	17. Father's Name (First, Middle,	Last)					18.Mothe	er's Name (First, Middle				
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica FO BE COMPIE		Michael	McVear	ry				Kath	leen	De1a:	nev		
D 21 thould Me is ma affic ever	19a. Informant's Name/Relations				-	Address (Stre				•	•		
Baltimore, MD 21215-0036 permit. Pages I and Should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f showing or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Michael A. McVe	earry/ Son				erbyshi			Riva, Date	Mary	land Location - 0	2114	O State
Ore	1 X Burial 2 Cremation	3 Removal fr	om Ctota	cremate	orv or othe	er place)		1				-	Le,Marylano
it. Pa	4 Donation 5 Other St. 21. Signature 6 unergy visice	pecify:		akeiioi					•				,
Ba perm Depa Impo		Licensee											al Home ID 21037
Physician	23a. Part I. Enter the disease, or		aused the dea	ath. Do no									Approximate Interval
/Medical Examiner	failure. List only one cause Immediate Cause (Final disease		one an	d al	coho1	intoxi	icati	on					Between Onset and Death
Examine	or condition resulting in death)	Due to (or as a										\neg	
<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence	e off.								\rightarrow	
ii ii	cause. Enter Underlying Cause (Disease or injury that initiated	С		·									
ted Insit Examine	events resulting in death) Last	Due to (or as a	consequence	∋ of):									
execut an and al - tra	XUNPENDED	dAMENDED						/10 ==				-	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be excouted hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and appletely filled in by the funeral director, page 2 should be detached for use as the burial - transit direal Certification: To Be Completed by Physician/Medical Ex.	IF FEMALE:	23a	28 و / 2 و. outcome of pr	a-f,	permb	g,. g902	2 4/8	/10 1	.T	23d	l. Date of d	delivery	
687 ertific ding p e as th	23b. Was decedent pregnant in the past 12 months?	1 Live b	oirth	2	=	death 3	Ectopi	ic pregnand	СУ		Month	Day	y Year
by the attending the for use an order fo	1 Yes 2 No 9 Unk	nown 9 Unkno	ant at time of	death 5	Othe	er (Specify)							
P.O. Box 687 s that the death certific gred by the attending p edetached for use as the by Physician/I	Part II. Other significant conditi			t resulting	in the un	derlying cause	given in Pa	art I.	23e. Did	tobacco u	ise contrib	oute to the	e cause of death?
s, P.O. signed by I be detac									1 🗌 Y	es 2	No 3	Probab	bly 4 🗸 Unknown
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eco he law ate has age 2 :										ormed?	de	eath?	2 No
ital Recoriclan: The law is certificate has be rector, page 2 sh	25. Was case referred to medical					26.Place	of Death	(Check on			1 .	7 700	2 110
Division of Vital rate of a vital arter death. Is after death. In Director: After this certice in the funeral director arter of the property of the funeral director artification: To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 1	npatient 2	ER/Ou	ıtpatient	3 DOA	Other ₄	Nursing	Home 5	Resider	nce 6 🗸	Other: S	cene
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Division o spital or Attending hours after death. neral Director: Aft filled in by the fune Certification:	deter	d not be 28e. Place mined (Specify)				factory, office t	building, et		or Town,	(Street an State) 1 (id Number 5062	Eng1	Route Number, City ish Oak
Division Hospital or Attence 24 hours after death Fruncral Director: tely filled in by the al Certificatic	4 Homicide 29a. Certifier 1 Certifying Ph	ysician: To the bes					ate and nic						
Di To the Hospital of within 24 hours at To the Funeral I completely filled	(Check only 1 Certifying Pinone) 2 Medical Exar	miner:On the basis of	of examination										ause(s)
To with	29b. Signature and title of certifier	and manner s	ialeu.			29c. Licens	e number			29d. D	ate signed	d (Month,	, Day, Year)
	0_10_	- m				O.C.	M.E.			Marc	ch 22, 20	010	
	30. Name and address of person	•	,	,									
	Donna M. Vincenti, M.				111 F	Penn Street,	Baltim	ore, MD	21201				
State Registrar	31. Date filed (Month, Day, Year)	D 0044	gistrar's Signa	acure	1								
OHMH 17 Rev 1/2001	AFKV	7 2010	enve	ORI	GINAL	all of							
COLUE COCCO				J. 11									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Month 3. Time of Death Physician/ 0348 BETTY ANN MORRIS 2010 arch Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Talbot Easten Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Days Hours Min (Month, Day, **Director** 214-34-5975 1935 Maryland Usual Residence of Decedent Department of Health and Mental Hygiene. Important: fittem 23a or 28a-f shov important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Talbot MD Easton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Washington St. Apt 203 21601 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u> Administrative Assistant|State of Maryland</u> 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Morris Bertha May Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh trent of Health a tant: If item 27 i E. Jay Lewis, Jr. Nephew 6680 Manadier Rd. Easton, MD. 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Doration 5 ☐ Other (Specify) Chesterfield Cem. 4/5/10 Centreville, MD. 21. Si matur Funeral Sen Licersee 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech M00510 118 West Cross St Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ hea rac disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner roid ears Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for an a number of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 1 Yes 2 No Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? by Mellitus 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy r this certificate h Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA မ 1 Inpatient Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 \square Pending work?
1 Yes 2 🗌 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, thin 24 hours after of the Funeral Director mpleted filled in by City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2.

To the F
complet only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) March 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton MD 21601 555 Inwood 31. Date filed (Month strar's Signatur State Registrar

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician 20 2010 12:30 P M Wanda Nellie Nuse /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Northhampton Manor If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)
12/17/1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Maryland 217-28-2161 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examiner must be notified at once. Director Y☐Yes 2☐No Frederick Brunswick MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 230 West Potomac Street 21716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: White <u>ā</u> 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Oscar Merriman Annie Keefer Simons ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 311 Brunswick St. Brunswick MD 21716 Cathey Dawson, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 3/22/2010 Hagerstown MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John T Williams Funeral Home Brunswick MD 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myo cardia Minuter **Physician** /Medical Due to (or as consequence of): **Examiner** extension Sequentially list conditions, Due to (or as Nonsequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown signed be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: in by the 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 29c. License number D43091 3-22-10 House Are, Franch MO 2170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL Saced Zardi 801 MM Q 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		For State Registrar	State of Mar	yland / E		nt of He	alth and M	fental Hy	giene		
Physicia	ın/	1. Decedent's Name (First, Middle,	,		00,0,,,00			2. Date of De Month MARCH			3. Time of Death
Medic Examin		PATRICIA 4a. Facility Name (If not institution, g FREDERICK MEM)		ORR		y, Town, or Lo	cation of Death	MARCI	4c.	County of Death	10:25A M
Funeral Director		5. Social Security Number 215-34-3094		n yrs. last birth		er 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov 19	:h		lace (State or Foreign
Maryland 28a-f show otified at	rector	Usual Residence of Decedent 10a. State 10b. County Maryland Freder		Oc. City, Town				_		10	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
th with the ms 23a or 2 must be no	Funeral Director	10e. Street and Number 5017 Mallard Lan	ie		10f. Z	ip Code 703			USA	izen of What Coun	
rs after dea ıral", or iter Examiner		 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced 	12. Was Decedent Eve Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates.		If Yes, spe	edent of Hispa ecify Cuban, N 2 X No S	inic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - America Black, White, e Specify: Whit	etc.
ithin 72 hou ene. • than "natu he Medical	Completed by	15. Decedent' (Specify only highest Elementary/Seconday (0-12) 12			Decedent's Us (Give kind of willife. DO NOT us Set Man	ork done durir se retired)	n ng most of worki	ing		nd of Business Ind	lustry
d be filed with the filed with the fired other the file event, the file event, the file event, the file event, the file event, the file event, the file event the file even	To Be (17. Father's Name (First, Middle, Last Charles Walter I	•	Ke	Sec Mai	18	. Mother's Name	•	Maiden S	Surname)	sty Stole
nd 2 shouk lealth and N m 27 is ma her trauma		19a. Informant's Name/Relationship Bill F. Orr, Jr.		18	9 Orr D	rive,				Town, State, Zip C Carolina	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Duneral Service Lice	ecity)	cemeter	22. Name a	other place) rial P and Address o	ark 3/2	esworth	Rock -Wil		
Physician/ Medical		23a. Part I. Ener the disease, or consider, or learn failure. List only Immediate Cause (Final disease of explition resulting in death)	omplications that caused the		ot enter the mo	de of dying, s	uch as cardiac o	r respiratory an	est,		Approximate Interval Between Onset and Death
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ath certificat attending ph for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of 1	Fetal death	3				2	23d. Date of delive Month	ry Day Year
v requires that the de been signed by the should be detached		Part II. Other significant condition	s contributing to death but	not resulting in	the underlying	cause given	in Part I.	23e. Did to		se contribute to the	e cause of death?
rsician: The law req s certificate has bee director, page 2 sho	Completed by							24a. Was autop perfo 1 Yes		prior to con death?	sy findings available inpletion of cause of
Physician: this certific ral director,	: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of injury	2 🗆 ER/Out	patient 3 🗆 [Other:		me 5 Resid		Other (Specify)	
or the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	(Month, Day, Y	ear) in	jury M	work?	2 🗆 No	28d. Describe h	treet and	Number or Rural I	Route Number,
le Hospital on 24 hours at le Funeral Dieted filled in	Medical C	(Check 2 Medical Exa	Physician: To the best of my aminer: On the basis of exan Jurse Practioner: To the bes	nination and/or	investigation, ir	my opinion, o	leath occurred at	d due to the car the time, date a	use(s) and	and due to the caus	se(s) and manner stated
To th withi To th	-	29b. Signature and title of certifier	: MD		29	MDD (mber 09430		29d. Date	e signed (Month, D	ay, Year)
10		Nega Ali Go	1 400 W	h (Item 23a) (T	ype, Print) enth S	treet	Fred	erick	Ma	ryland	21701
Stat Registra	e ir	31. Date filed (Month, Day, Year)	3 2010 Registrars	sum /	8. pa	Med					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 19. Physician 2010 Raymond Ivan March 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** 106 Windmill Road Conowingo Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan. 26. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) 940 **Funeral** Months Days Hours Min. Country) Maryland 1 € M 2 □ F Jan. 212-38-0670 70 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It a Medical Examination that be called an once. 1 ☐ Yes 2 X No Director Conowingo Cecil Maryland with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21918 U.S.A. 106 Windmill Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: Vietnam 1 ☐ Yes 2 💢 No Specify: Specify: <u>چ</u> White 3 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Twelve Years College (1-4or 5+) United States Army Master Sergeant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Martha Updyke John Raymond Orem ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Windmill Road, Conowingo. Maryland 21918 19a. Informant's Name/Relationship (Type. Print) Doris H. Orem (wife) Baltimore, 20c. Location - City or Town, State West Chester, Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State R.A.Ferris & Co., Inc. 03/25/10 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen Name and Address of Facility ee A. Patterson & Son Funeral Perryville, Maryland 21 al Home, P 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** and disease or condition resulting in death) /Medical Due to (of as a consequence of): Adrena Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed?

1 □ Yes 2 No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 24 hours after death.

Funeral Director: After etely filled in by the funera 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature a thile of certifier 29c. License number

State Registrar

as Rond

Name and address of person who completed cause of death (Item 23a) (Type,

NAR 25

31. Date filed (Month, Day, Year)

			Please Type or Print i				-	other other 1 other	10711
			State of Maryl	-	rtment of He tificate of De				10/11
			Registrar 1. Decedent's Name (First, Middle, Last)	Ceri	ilicate of De	eatri	2. Date of Death	g. No.	3. Time of Death
	Physicia Medic		Louis Jonathan Palmatary, I	I			MARCH	2Î ^y 20ÎÖ	4:28 PM
	Examin		4a. Facility Name (if not institution, give street and number) 410 WILL SMITH ROAD		4b. City, Town, or L			4c, County of Death	
# . m *	Funeral		5. Social Security Number 6. Sex 7. Age (In v	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	g, Birth	nplace (State or Foreign
н	Director		216-78-1948	9 Yrs.	Months Days	Hours Min.	8/211/196	Cou	mtry) MD
	and show lat	or		. City, Town or Loc	ation				10d. Inside City Limits
	Maryl 28a-f otifiec	irec	MARYLAND QUEEN ANNE'S	HENDERSO	ON				1 🗆 Yes 2 🛣 No
	th the	Funeral Director	10e. Street and Number		10f. Zip Code 21640		10	g. Citizen of What Cou USA	untry?
	ath wir ems 2 musi	nner	410 WILL SMITH ROAD 11. Marital Status 12. Was Decedent Ever in	n U.S. 13. W		panic Origin? (Spe	cifv Yes or No-	14. Race - Ameri	ican Indian
920	should be filed within 72 hours after death with the Maryland I and Mental Hygiene. Is marked other than "ratural", or items 23a or 28a-f show is marked other than "ratural".	Completed by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		/as Decedent of His Yes, specify Cuban ☐ Yes 2 X No		Rican, etc.)	Black, White	
21215-0036	72 hou n "natu fedical	nplet	15. Decedent's Education (Specify only highest grade completed)	I (Give k	ent's Usual Occupat ind of work done du DNOT use retired)		ng 16	6b. Kind of Business I	ndustry
212	within giene. er tha		Elementary/Seconday (0-12) College (1-4 or 5+)	Farme	*			Agricultu	ire
pu	filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last) Louis Jonathan Palmatary				e (First, Middle, Ma		
Maryland	uld be d Men marke natic			100 14 15			Sylvester		Codol
Mai	2 sho Ith and 27 is r traur		19a. Informant's Name/Relationship (Type, Print) Lisa C. Palmatary/ Wife	1	g Address (Street ar Vill Smith			ity or Town, State, Zip MD 21640	Code)
	ie 1 and 2 s t of Health If item 27 i or other tra		20a. Method of Disposition	0b. Place of Dispos				0c. Location - City or	Town, State
imo			1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Sudlersv		3/27	7/10 s	udlersvill	e. MD
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	$\frac{2^2}{F\epsilon}$	Name and Address			m Funeral eville, MD	
			23a. Part 1. Enter the disease, or complications that caused the						Approximate
	hysician/	2 /2	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	shace		Cance	V		Interval Between Onset and Death
	Medical Examiner		resulting in death) a. Due to (or as a con	equence ():					
	Lammer	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cor	assertience of).					
	ted J Insit	Examine	cause. Enter Underlying Cause (Disease or linjury	1354451155 51/1					}
	cate be executed physician and the burial-transit		that initiated events c. resulting in death) Last Due to (or as a cor	nsequence of):					
09	ate be physici the bu	dica	d				· · · · · ·		
x 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, cutcome of pr	Fetal death 3 🗆	Ectopic pregnancy	,		23d. Date of deli	ivery Day Year
. Box	ne dear y the ar ched fo	nysic	1 Yes 2 No 9 Unknown	e of death 5 L	Other (specify)				
P.O.	es that the igned by t be detach	by P	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.		acco use contribute to	L .
ds,	requires been sig should b	ted					1 L Yes	2 □ No 3 □ Pr	
Records,	law re has be	Completed					24a. Was an autopsy perform	prior to c	copsy findings available completion of cause of
R	ician: The la certificate ha rector, page		25. Was case referred to medical		26 Pla	ce of Death (Checi	1 🗌 Yes 2	Yo 1 ☐ Yes	P No
of Vital	ysician: is certific director,	To Be	examiner? Hospital:	2 ER/Outpatien	Othor	y-	1	ce 6 Other (Speci	ify)
of	ng fter ine		27. Manner of Death 28a. Date of injury (Month, Day, Yes	28b. Time of	28c. Injury work?	at	28d. Describe how		
ion	ttendii death. tor: Ai	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	At home farm street		Yes 2 □ No	78f Location /Stro	eet and Number or Rur	ral Route Number
Division	al or At s after il Direc ed in by		4 ☐ Homicide determined 200. Place of Injury - building, etc. (Sp.		et, factory, office		City or Town,		ai noute Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier 1 Certifying Physician: To the cest of my Check 2 Medical Examiner: On the casis of exami	ination and/or invest	igation, in my opinior	n, death occurred a	t the time, date and	place, and due to the o	cause(s) and manner stated.
	To the within 2 To the comple	Σ	only one) 3 Certifying Nurse Practiculer: To the best 29b. Signature and fittle of certifier	or my knowleage, o	29c. License			d. Date signed (Month	
	2)		Valent Murx	shyskia	n Hous	5782		3/23/	2010
	ms		30. Name and address of person who completed cause of death	(Item 23a) (Type, F	Print)	VALER	IE GO	, 21617	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's S	Signature (envel	mu / h	<i>x</i> ()	1 -1611	
	D. C.		240 9 4 9010 1/2 400	A. D. B	-				

Physicia /Medica Examine

Funeral Director

	1 - State of	i waryiand		rtificate of	Death	Re	eg. No.	010	107	12
an	1. Decedent's Name (First, Middle, Last) William Francis P	rice				2. Date of Deat Month March	Dav	010 ^{Year}	3. Time of D	
al er	4a. Facility Name (If not institution, give street and nut	mber)		4b. City, Town, or SNOW	r Location of Death HILL		4c. Cou	unty of Death		
	5. Social Security Number 222-16-4757 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. la 82	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 09 16]	Year) 19 27	Cou	nplace (State or intry) ryland	Foreign
	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City	Limits
ctor	Maryland Worcester		Snow						1 2 Yes 2	2 No
ral Dire	10e. Street and Number 430 W. Market Street			10f. Zip Code 2186	53	1	0g. Citizen US	of What Cou	intry?	
Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dece Armed For 1 Yes, Giryear or D	2 ∑X No ve		Was Decedent of H fYes, specify Cuba 1 □Yes 2 🛱 No	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)		Race - Amer Black, White, ecify:		
lete	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	dent's Usual Occup kind of work done	oation during most of work d)	ing	16b. Kind o	of Business/II	ndustry	
ошо	Elementary/Secondary (0-12) College (1	-4or 5+)			nt operat		agri	.cultur	ce	
To Be C	17. Father's Name (First, Middle, Last) George Price	,			18. Mother's Name		faiden Sur	name)		
	19a. Informant's Name/Relationship (Type. Print) Susan Rantz/daughter		19b. Mailir 61	ng Address (Street 03 George	and Number or Rui e Island	al Route Number Landing	; City or To Rd • , S	wn, State, Z Cockto	ip Code) On, MD218	364
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 (3 Donation 5 ☐ Other (Specify)	State I	-	sition (Name of natory or other place ifts Regi		Date 23 10		ion-City or T	_	
	Signature of Funeral Service Licensee	X			fuheral H Hill Rd.,					ion
	resulting in death)	aused the death. ach line. LEBOLOL (or as a conseque	/As U		ACCIDEA		est,		Approximate Interval Betwo Onset and De	reen
edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequi								
Completed by Physician/Me	in the past 12 months?	come of pregnar birth 2 Fetal nant at time of de own	death 3[Ectopic pregnand Other (specify)	y		23d	. Date of deli Month		ear
d by Ph	Part II. Other significant conditions contributing to de	eath but not resul	ting in the u	nderlying cause giv	ren in Part i.	23e. Did tot			the cause of de	
complete						24a. Was a autops perforr	y	24b. Were aut prior to c death? 1 ∐Yes	topsy findings as completion of car	vailable use of
Be (25. Was case referred to medical examiner?			201	26. Place of Deat					
To	1 ☐ Yes 2 ☐ Hospital: 1 ☐ 27. Manner of Death 28a. Date	Inpatient 2 E	R/Outpatier		4 Nursing Ho	ome 5 Reside			cify)	
Medical Certification: To Be	1 Natural 5 Pending (Mon 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	th, Day, Year)	Injury ne, farm, str	Wor	kʻ?¯¯¯ Yes 2□No	28f. Location (St	reet and N		ral Route Numb	er,
cal Cer	29a. Certifier (Check only 2 Medical Examiner: On the b	best of my know	vledge, deat	h occurred at the ti	me, date and place	, and due to the o	ause(s) an	nd manner as	stated.	
Medi		mer stated.		29c. Licens		2	9d. Date s	igned (Month	n, Day, Year)	
	30. Name and address of person who completed cause ShARAD R SAMAC,	se of death (Item	23a) (Type,	Print) MMCET	ST Pocor	noke a	M a	10 2	1851 .	
te ar	31. Date filed (Month, Day, Year) NAR 2 3 2010	egistrar's Signati	de de	العاد						

DHMH 17 Rev 1/2001

State Registra 10-02525 Jerry Perry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jerry Perry		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 20 0 0 7	(
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year March 30, 2010 3. Time of Death Month Day Year 1030 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hospital 4c. County of Death Chevely Prince George's	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 6. Sex 1 7. Age (In yrs. last birthday) 6. Sex 1 7. Age (In yrs. last birthday) 6. Sex 1 7. Age (In yrs. last birthday) 6. Sex 1 7. Age (In yrs. last birthday) 6. Sex 1 7. Age (In yrs. last birthday) 6. Sex 1 7. Age (In yrs. last birthday) 6. Sex 1 7. Age (In yrs. last birthday) 6. Sex 1 7. Age (In yrs. last birthday) 6. Sex 1 7. Age (In yrs. last birthday) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 7. Age (In yrs. last birthday) 6. Sex 1 7. Age (In yrs. last birthday) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6. Sex 1 8. Date of Birth(MM/DD/YYYY) 9.	ri
any		Usual Residence of Decedent 10a. State	its
	-c	Maryland Prince George's Largo 1 X Yes 2 N	чo
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 394 Harry S. Truman Drive 10f. Zip Code 20774 USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a, or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1	
ours afte atural", caminer	d by	3 K Widowed 4 Divorced of Divo	_
(36 hin 72 h e. than "n adical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Covernment	
15-00 filed with Hygien d other	Con	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)	_
212' ould be d Mental s marke	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
, MD and 2 sh lealth an tem 27 i		William J. McHugh (Brother) 4012 McRee Avenue, St. Louis, Missouri 63110 20a. Method of Disposition Date 20c. Location - City or Town, State	
MOFE Pages 1 nent of H ant: If i		1 Nonation 5 Other Specify: crematory of other place) 4 Donation 5 Other Specify: crematory of other place) Harmony Memorial Park 4/7/2010 Landover, MD	
Balti permit, Departn Import		21. Signature of Funeral Service Ptensee, 22. Name and Address of Facility Latimore Funeral Services, P.A 9013 Annapolis Road, Lanham MD 20706	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interv	
Examiner		Immediate Cause (Final disease or condition resulting in death) Anaphylactic reaction Due to (or as a consequence of):	
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause.	
uted d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.	
50, te be executed ysician and eburial - transit	edical	X UNPENDED AMENDED PI line a-b, PII,27,28a-f,permE, g902 4/15/10 TT	
6876 certifica nding ph	ΙŚΙ	IF FEMALE: 23b. If yes, outcome of pregnancy 1 Live birth 2 The past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	
). Bo the dear by the ar	Ph.	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	_
S, P.(uires tha n signed Id be det	ed by	Hypertension 1	
S a a S	Completed	24a. Was an autopsy findings availab prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
Vital Rec hysician: The this certificate	o Be (25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Other: 4 Nursing Home 5 Residence 6 Other:	
n of ∖ iding Phy h. : After the		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred subject had a reaction to	
Division of N pital or Attending Ph, ours after death eral Director: After ti	Certification:	Accident Investigation Investi	ty I
To the Hospital within 24 hours To the Funeral completely filled	ledical Ce	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
Ţ.≱₽.Ş	Me	29b. Signalure and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) March 31, 2010	
0 1		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	_
, C	tate	31. Date filed (Month, Day Year) 32. Register's Signature	_
Regis	trar	1 NOW 11 2 MINU (AMONTO P. P. P.)	

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			State of Maryland / Department of Health and Mental Hygiene	711
			1 - State Registrar Certificate of Death Reg. No. 2 U U U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3. Time of Death 3. Time of Death 3.	/ L
	Physici /Media		Month Day Year	OO AM
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
2.15			REEDER'S MEMORIAL HOME 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State	or Foreign
- 1	Funeral Director		214-28-0613 1 M 2 M F 80 Yrs. Months Days Hours Min. SEPT. 30, 1929 MARYLAND	or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside C	City Limits
	Maryla f sho	ō		s 2X No
1	r 28a-	Director	The Distriction of the Control of th	
	death with the Maryland rns 23a or 28a-f show rnust be rollfled at		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA	
RUTH 5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extractings be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes 2 ☒ No Specify: WHITE	
275	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of working life. DO NOT use retired)	
38	filed within Hygiene. other than '		CLERICAL printing	
BE I	ould be filed Mental Hygi arked other atic event,	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY AGNES MARKER	
POFFENBERGE	should I and Men is marke	은	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
POF	1 and 2 Health a em 27 is		RICHARD POFFENBERGER/husband 11812 ROBINWOOD DRIVE, HAGERSTOWN, MARYLAND 21	742
NAME: P. Baltimore,	Pages 1 ment of H ant: If ite ury or ot		20a. Method of Disposition 1 [X] Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) ST. PAUL S LUTHERAN APR.5, 2010 MYERSVILLE, MARYLA	AND
NAME Baltin	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7. Signature of Funeral Service Licensee 7. Signature of Funeral Service Licen	}
	460		23a. Part 1. After the 1 et a. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart f liure. List only one cause on each line. Approxima	ite etween
	Physician		Immediate Cause (Final disease or condition	Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	
0		e.	Sequentially list conditions, if any leading to immediate the control of the cont	
	executed n and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
ó,	ficate be executed physician and s the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):	
8760,	ate b	edical	d	
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	Year
	that i	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of	death?
rds	quires en sig uld be	ed b	Hypertension, Diabetes mellitus 1 yes 2 pho 3 probably 4	Unknown
Division of Vital Records,	: The law re cate has be page 2 sho	Completed	24a. Was an autopsy findings prior to completion of death? 1 \[\text{Yes} 2 \] \[\text{No} \] 1 \[\text{Yes} 2 \] \[\text{No} \]	s available cause of
Vit	sician certif rector	Be	25. Was case referred to medical examiner? Hospital: The state of Death (Check only one) Other: Death (Check only one)	
of	I Physer this eral di	2	27. Manner of Death 28a. Date of Injury 28b. Time of 28c, Injury at 28d. Describe how injury occurred	
on	nding ath. r Afte f fune	atior	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	
ΝİS	r Atte ter dea irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)	mber,
	bours of hours of numeral Di filled in		29a. Certifier (Check only (Check only and due to the cause(s) and manner as stated. (Check only (Che	(a)
	the Ho thin 24 the Fi	Medical	one) and manner stated.	(0)
	6 ½ 6 0		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doo 63233 04/02/20/0	
T		1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
			Dr. Shahid Mahmood 580 Northern Avenue, Hagerstown, MD 21742 301-733-4496)
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ukani, maddock kachipande. Prenatt 10 55 AM March 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Iniversity of Mary land Medical cente Baltimore 8. Date of Birth (Month, Day, Year) Mar, 25, 2 Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1.8 M 2 🗆 F Hours Months Country) Director Usual Residence of Decedent shov 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MONTGOMERY GERMANTOWN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19147 HIGHSTREAM 20874 DR. hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify BIRACIAL 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) N/AN/A2 should be filed with h and Mental Hygien 7 is marked other th 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MATTHEW DAVID PRENATT THOKOZILE PRIMROSE KACHIPANDE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau MATTHEW PRENATT FATHER 19147 HIGHSTREAM DR., GERMANTOWN, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETERY: 4/2/2010 4 Donation 5 Other (Specify) RESTHAVEN FREDERICK, MD 21. Signature of Funeral Service Lice s e 22. Name and Address of Facility HILTON FUNERA P.O. BOX 86. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition Sensis Medical resulting in death) Due to (or a a consequence of) Examiner potension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (a consequence of): that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): and -trar resulting in death) Last burialattending physician for use as the buria Physician/Medical eviere Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death 1 Yes 2 No been signed by the should be detached g Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed?/ Yes 2 2 No 1 Yes 25. Was case referred to medica examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this (4 Nursing Home 5 Residence 6 Other (Specify) After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu М 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe MD 12612010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Konduru, 295 Greene Kavitua MD Baltimore 2120 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 83nth Physician/ Prematt Micah Zenzele Kachipande. 2010 00:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Ballimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 XM 2 | F Min. Hours Country) Director MD Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director GERMANTOWN MD MONTGOMERY 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20874 USA 19147 HIGHSTREAM DR. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: an "natural", e Medical Exan If Yes, Give Year or Dates Specify: BIRACIAL 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the N/AN/A 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ THOKOZILE PRIMROSE KACHIPANDE MATTHEW DAVID PRENATT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19147 HIGHSTREAM DR., GERMANTOWN, MD 20874 MATTHEW PRENATT / FATHER or other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
RESTHAVEN CEMETERY 4/2/2010 FREDERICK, MO 4 Donation 5 Other (Specify) 22. Name and Address of Facility
HILTON FUNERA
P.O. BOX 86. 21. Signature of Funeral Service Libenses N 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phlmonary hemorrhage Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): 484 Examiner Membrane Hyaline Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury 48 hr Pr amatherty Extrame physician and the burial-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? 2 Records, metabolic 0.210 05 13 1 ☐ Yes 2 🔀 No 3 🗋 Probably 4 ☐ Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? SEPSIS 24a. Was an autopsy performed? this certificate 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Other: 1 Alnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 18381 03 / 28 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene ST, suite 110, BALTIMORE, ND 2120 295 ovens GO d-CLARD 31. Date filed (Month, Day, 32. Registra s Signature State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Physician/ April 1. 1:00 PM M Bernard Thomas Price, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Frederick College View Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days 86 Months Hours Abril Day Year 217-12-2436 Maryland 192B Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natures" - " any injury or other trained." 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Frederick Frederick Yes 2 No Maryland 10f. Zip Code 21702 10e. Street and Number 10g. Citizen of What Country? 2402 Dominion Drive, Apt. 3 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc by 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. White Specify: 3

Widowed 4 □ Divorced Year or Date <u>1943-1946</u> Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) $\overset{\text{College (1-4 or 5+)}}{12}$ Elementary/Seconday (0-12) Civil Service Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dora Horman 0 Vernon Price 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 G Blue Leaf Court, Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) B. Thomas Price II, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2010 Frederick, MD Mount Olivet Cemetery April 6, 4 □ Donation XX Other (Specify) Entombment Sign of Fun e I Service Lic Keeney and Bastord PA Funeral Home M00255 106 Fast Church St., Frederick. 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a conse uen e of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): **To the Hospital or Attending Physician**: The law requires that the death certificate be executed arteria Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown COMCEV 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 🗌 Yes 2 🗎 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 PNursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural work? 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar Hemen

31. Date filed (Month, Day, Year)

APR O

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

D 60417

Frederick

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year)

APR 0

31. Date filed (Month, Day,

32. Registrat's Signature

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	Funeral Director		5. Social Security Number 080-74-6263	6. Sex 1 M 2 D F	e (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth ay, Year) 1929	9. Bird	thplace (State or Foreign untry) Salvador		
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Baltimore, Maryland 21215-0036	ent of H		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		ce	metery, crem	sition (Name of natory or other plan		Date 1/2010	20c. Location	•			
Baltin permit B	Departm Importa any inju	4 Donation 5 Other (Specify) Parkland Cemetery 3/23/2010 Rockville, M 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers—Durboraw Funeral 136 E Baltimore St, Taneytown, MD 2178												
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the disease of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the disease of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the disease of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the disease of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the disease of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the disease of the death.											
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Box 68760 death certificate b	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal	death 3	Ectopic pregnand	су			ate of deli	ivery Day Year		
P.O. I	ed by th detache	by Phy	9 Unknown Part II. Other significant condition		ut not resul	ting in the ur	nderlying cause gi	ven in Part I.	23e. Did t	obacco use cor	tribute to	the cause of death?		
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Div	neral Di neral Di d filled ir	edical C	29a. Certifier 1 Certifying	Physician: To the best of	my knowled	dge, death o	ccured at the time	, date and place, a	nd due to the ca	use(s) and man	ner as sta	ted.		
o the Ho	ithin 24 o the Fu omplete	Σ	(Check 2 \(\sumeq\) Medical E	xaminer: On the basis of ex Nurse Practioner: To the	kamination a	and/or investi	gation, in my opinic	on, death occurred a e time, date and pla	at the time, date a	and place, and di	ue to the c nanner as s	ause(s) and manner stated. stated.		
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	3		30. Name and address of person v	who completed cause of de	eath (Item 2	?3a) (Type, Pr	0	E. Ar	Tieta	m 5	740)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Mark Alan Reed March 16 6:43p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Months Days 1 3 M 2 □ F Hours Min Year) 1958 Director Yrs. 236-90-6461 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12318 Catoctin View Drive 21771 <u>United States</u> 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Computer Programer</u> <u>Geico Insurance</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William P. Reed Sr. Naomi Willetts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan L. Reed/ Wife <u> 12318 Catoctin View Drive,Mt.</u> Airy, MD 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation
☐ Other (Specify) Grove Cemetery 3/22/2010 Mt. Airv, Marvland 21. Signature of Mneral Service L 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Frederick, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or linjury tran Due to (or as a consequence of) resulting in death) Last ending physician use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Pregnant at time of death 5 Other (specify) Month the Yes 2 L No 9 Unknown P.O. ed by t Part II. Other significant conditions contributing to pleath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t lirector, page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No 1 L Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manper of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending of the safter death.

e Funeral Director; After detection of the function of t Accident Suicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted (Check within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifie 29b. Signatu 29d. Date signed (Month, Day, Year) MD D0059924 March 18, 2010 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) 10

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Mo

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nth. Dav. Year)

South Main Street # 202, Mt. Airy, Maryland 21771

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32. Registrar's Signature

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 ear March 21, Frederick Oscar Roelecke, Jr. 4:00 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Taneytown 4148 Bull Frog Road If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day,) June 12, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F Year) 927 Days 82 Yrs 214-24-4789 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Taneytown Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 USA 4148 Bull Frog Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) 10 College (1-4or 5+) Agriculture Dairy Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Meekins Frederick O. Roelecke, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4030 Bull Frog Road, Taneytown, MD 21787 Margaret Allick, sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/24/2010 Taneytown, MD Grace UCC Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licens Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death to Cause (Final

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

9

Completed

Be

filed within 72 hours after death with the Maryland Hygiene.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at

Baltimore, Maryland 21215-0036

/Medical

Examiner edical

attending physician and for use as the burial-transit

Division of Vital Records, P.O. Box 68760

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Hospital or Attending Physician: The law requires that the death certificate be executed nours after death. neral Director: Af y filled in by the fur To the Hospital or within 24 hours at To the Funeral D completely NJI 15

disease or condition	_a congeste Heart G	allur Suus
resulting in death)	Due to (or as a consequence of): b. Caronan brienn	Disease
Sequentially list conditions, and the minimum of the minimum of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a consequence of): d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy findings available prior to completion of cause of
25. Was case referred to medical examiner?		performed? death? 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA Other: 4 Nursing Horr	ne 5 Residence 6 Other (Specify)
27. Mann Death 1 atural 5 Pending 2 Accident investigati	on (Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	8d. Describe how injury occurred
1 Yes 2 TNo 27. Mann Death 1 Natural 5 Pending investigati 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 29b. Signature and title of certifier		8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical Ex	Physician: To the best of my knowledge, death occurred at the time, date and place, a similar: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	and due to the cause(s) and manner as stated. In add at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ma 21787

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis ar's Signature

1 ASON 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22, Day 2010 Month **Physician** March 1:05p M Geator Ralph Reeves /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil E1kton 97 5th Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct. 7, Oct. 7, 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 1932 MD 213-30-7437 77 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Funeral Director E1kton MD Ceci1 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21921 USA 97 5th Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ∏Yes 2 XX If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within . Department of Health and Mental Hygiene. mportant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Chrysler Corp. Assembly Line 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victoria A. Hart ပ Wiley A. Reeves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5th Avenue Elkton, MD 21921 Ruby A. Reeves/ wife Important: If item any injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/26/2010 Elkton, MD Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R.T. Foard and Gee 259 E. Main St. Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 HInknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2. 29d. Date signed (Month. Dlav. Year) 29c. License number 29b. Signature an title of certifier MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson, MD 133 N. Bridge St. Elkton, MD 21921 31. Date filed (Month 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 9:52 M 2010 Pauline Records Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SA4Sb4N HICUMICO MINSYLA REGIONAL If Under 1 Year If Under g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1 🗆 M 2 💢 F Months Days (Month, Day, Year 10-8-1934 Country) Mary Land Director 75 218-30-1410 Usual Residence of Decedent show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Pittsville Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7310 Pine Street 21850 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12 Optometry Optician is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Taylor E11a Shiffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health Richard Records - Husband 7310 Pine Street, Pittsville, MD 21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (State) Page 1 o = Department of Important: If it any injury or o Donation 5 - Other (Specify) Pittsville Cemeterv 3-22-2010 Pittsville, Maryland Signature of Funeral Service Licen 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TERICARDIAL TAMPO NADE disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami FACUTA NEOUS that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical ASCVO Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death the 9 Unknown P.O. Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Tunknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 Yes Yes Division of Vital the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Nation 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After 1

mpleted filled in by the funera 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the comple 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

100 E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M Roberson Dorothy Mildred Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-RMC Cumberland Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** Min. 1 M 2 DF Days Hours Jun 27 ^{≗a}1929 Director 220-26-9348 80 ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10d, Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Cumberland MD Allegany 1 XYes 2 No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21502 USA P.O. Box 365 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Marital Status 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give Maryland 21215-0036 1 🗆 Yes 2 🗖 No Specify. Specify: white 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Floral World owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Mildred Catherine (Wagner) Smith Cloyd Raymond Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip P.O. Box 365 Cumberland 19a. Informant's Name/Relationship (Type, Print) MD 21502 Henry Roberson husband item 2 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 a ₹ Important: If it any injury or o Restlawn Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State 4/3/2010 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pe disease or condition Medical resulting in death) a consequence of **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of, if any, leading to inniectate cause. Enter Underlying Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnap 3 Ectopic pregnancy
5 Other (specify) in the past 12 months for Month Dav Year Pregnant at time of death 2 No should be detached 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 death? 1 Yes 2 No 20 No 1 Yes Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA မ 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 Yes 2 No 1 Natural 5 Pending iours after death.

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filled in by the fur Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

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completed filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 5 29c. License number 30. Name and address of person who co ed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Oly

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James P. Strain 4:43 P [™] March 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mallard Bay Care Center Dorchester Cambridge 8. Date of Birth (Month, Day, Year) March 13,1944 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 181-34-5233 1 X M 2 □ F 66 Pennsylvania **Director** Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a, State items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the insidest Evaninar must be notified at Dorchester 1 ☐ Yes 2 1 No Director Woolford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4905 Longview Road 21677 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 🙀 No If Yes, Give Year or Dates; 1 Never Married 2 Married 3altimore, Maryland 21215-0036 white 1 □Yes 2 No Specify Specify þ 3 Widowed 4 Divorced n and Mental Hygiene. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) construction manager construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James R. Strain Anna Fothergill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Jan R. Strain wife 4905 Longview Road, Woolford, MD 21677 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 I Burial 2 ☐ Cremation Style Removal from State Plum Creek Cemetery 3/26/10 Plum Boro. PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician DAtocellu resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if they cause in the Underlying Cause (Disease or injury that initiated events resulting in death) Last Oue to for as a consequence of Examiner -transit law requires that the death certificate be executed Due to (or as a consequence of): attending physician a Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached o 9 Unknown 9 Unknown ٣. signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ∐ Yes 2 **⊈** Ao 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 XIN director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐪 0 ို 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Certification: or Attending 1 Natural 5 Pending within 24 hours after common to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 182 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

30. Name and apdress of person who

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MAR 25 201

31. Date filed (Month, Day, Year)

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21613

completed cause of death (Item 23a) (Type, Print)

D.O.

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23 2010 Year MARCH HILLARY WOODROW SCOTT 9:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **QUEEN ANNE'S** CENTREVILLE CORSICA HILLS NURSING HOME Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🗙 M 2 🗆 F MARYLAND Director 215-36-7389 71 1939 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD CAROLINE HENDERSON 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21640 23820 BRIDGETOWN ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER TRUCKING 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ARCHIE SCOTT GLADYS RAMSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA ANN SCOTT/WIFE 23820 BRIDGETOWN ROAD, HENDERSON, MD 21640 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARCH 27, CHESTERFIELD CEMETERY CENTREVILLE, MD 2010 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ END STAGE RENAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: burial-transi that the death certificate be executed DIABETES me that initiated events Due to (or as a consequence of): resulting in death) Last ng physician as the burial Physician/Medical Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No ed by the a detached t 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by be detailed 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy performe certificate Yes 2 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 1 Natural 5 Pending 1 🔲 Yes 2 🗌 No death. Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Ecrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMSTRONG AVE CENTREVILLE MODICIT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 17 Rev 7/2009

MAR 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Evelyn V. Schattenberg 1^{Day} 2010 7:45a 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Tranquillity at Fredericktowne Frederick Frederick Social Security Number 7. Age (In yrs. last birthday 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 👿 F Months Days Hours Min 217-12-1365 Selbeth, Pg, 1924 85 MafyTand Yrs Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Maryland Frederick 1X Yes 2 ☐ No Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9507 Dublin Road 21793 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor County Facility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Kemp Lucy Bussard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ron Schattenberg/Son 9507 Dublin Road, Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Mt.Olivet Cemetery 3/22/2010 Frederick, MD 22. Name and Address of Facility Stauffer Funeral Home, PA . Signature of Funeral Service Licenses lin 10 1621 opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final approtin disease or condition resulting in death) Due to (or as a consequence of): Alzheimir Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 231 Pai 25.

Pnysician/ Medical Examiner

Exami

Physician/Medical

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Completed

Be ျ

Certificate:

Medical

27.

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Physician/

Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

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ral", or items 23a or 28a-f sho Examiner must be notified at

"natural",

other traumatic event, the Medical

and Mental Hygiene.

Health a

permit. Page 1 a Department of H Important: If ite any injury or otl

item

within 72 hours after death

Baltimore, Maryland 21215-0036

Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran ed by t s been signe should be c Jas page 2 After this of Funeral Director: Af Seted filled in by the fu

Division of Vital Records, P.O. Box 68760

o. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year				
Emphys		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Probably 4 Unknown				
Coson	ery certify Didean	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No				
Was case referred to medical	26. Place of Death (Check	ack only one)				
examiner? 1 🗌 Yes 2 🕱 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 🗆 Residence 6 🗀 Other (Specify)				
Manner of Death Natural 5 Pending Accident Investigat Suicide 6 Could no	on (Month, Day, Year) Injury work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred				
4 Homicide determine	1980 Diago of Injury At home form street featons office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1206186

29c. License number

6 State Registrar

within 24 ho

To the Fune

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 W. Ninth Street, Dr. Austin Pearre

Frederick, MD 21701

29d. Date signed (Month, Day, Year)

3/18

31. Date filed (Month, Day, Year) 32. Registrar's Signature arke MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F rtificate of I			eg. No 2010	10728
	Physicia		1. Decedent's Name (First, Middle, Las					Date of Death Month	Dav Year	3. Time of Death
	/Medic			neideman I	I	# 0" Town	al anation of Dooth	March 1	6, 2010 4c. County of Death	5:20 P M
	Examin	er	4a. Facility Name (If not institution, given 1211 Canon Way	e street and number)		Westmins	r Location of Death		Carroll	
**	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign intry)
	Director		269-40-8136	5±M 2□ F 65	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 7,	1944 Ohic)
	pur "		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	f sho	ō								1 ☐ Yes 2 ☐ No
	the N	Director	MD Carroll 10e. Street and Number		Westmins	10f. Zip Code		1	0g. Citizen of What Coυ	untry?
	h with		1211 Canon Way			21157			U.S.A.	
	deatl	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14, Race - Amer Black, White	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Weden Evaninar must be notified at	by	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	No	1 □Yes 22D4No	Specify:	,		white
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121	filed within Hygiene. xther than "	dm	Elementary/Secondary (0-12)	College (1-4or 5	+) Chief	Executive Executive	ve Office:	r	Specialty T Contracting	
	filed v Hygid ther		17. Father's Name (First, Middle, Last)	4			18. Mother's Nam			1
an	wild be filed Mental Hygi arked other atic event, I	To Be	Edward Smith Sche				Wilma B	roz		
ary	should I and Men s marke	-	19a. Informant's Name/Relationship (ing Address (Street	and Number or Rui	ral Route Number	; City or Town, State, Z	(ip Code)
Σ	and 2 salth a n 27 ls		Karen E. Scheidem	an - Wife	20b. Place of Disponentery, cre				MD 21157	
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health s Important: If item 27 Is any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	/2010	20c. Location - City or Town, State Hampstead, MD					
Balti	permit. Departm Importa any inju		21. Signature of Edneral Service Lice		eral Home 8 ster, MD 2	& Chapel,PA 1157				
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nd,	Physician		Immediate Cause (Final disease or condition	one cases on each in	COTHI	ELID N	AC			Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a consequence of):					
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	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
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0.	ne dez the at	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death 5	Other (specify) _				24,
σ.	that the		Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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Be	The law te has	mo						autops perfori 1 🗆 Yes	med? death?	completion of cause of
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isio	Attending in death. ector: After by the fune	icat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 200 Place of Ini	ury - At home, farm, s		Yes 2 No	28f Location (S	treet and Number or Ru	ıral Route Number.
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_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		29a. Certifier 1 Certifying P	hysician: To the best	of my knowledge, dea	ath occurred at the tinvestigation, in my	time, date and place	e, and due to the our	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	the H hin 24 the F nplete	Medical	one)	and manner st		29c. Licen			29d. Date signed (Mont	
	5 № 60 00		29b. Signature and title of certifier	tor	W	1200. 210811	T 39 ×		2-18.	-10
J,	st.		30. Name and address of person who	completed cause of a	leath (Item 23a) (Type	Print)	2016		~ 14	10
J	30		Flavio Muto 555	0	1 ~ 1	1 2-1	inster,	HD 2115	57	
	Sta		31. Date filed (Month, Day, Year)	32. Régistr	ar's Signature	bake				
	Registr	ar	MARIS	LUIU Line	va p. 19	-				

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	For State Registrar		State of N	naryian	•	artment of I tificate of L		and N	/ieritai my	Reg. N	-/1	010	10729
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Medic Examin		4a. Facility Name (if	not institution, g	give street and number)		(ente	4b. City, Town, o	r Location	of Death		4	c. County	y of Death	
Funeral Director		5. Social Security Nu 220–18–6		5. Sex 7. A	ige (In yrs. k	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	av. Year)	5	Cour	place (State or Foreign
how at	ř	Usual Residence of 10a. State			10c. Cit	y, Town or Lo	cation			100 113				10d. Inside City Limits
e Maryla r 28a-f s notified	Funeral Director	Maryland	Worce	ester	S	now Hi	11 10f. Zip Code							1 🗌 Yes 2 🔀 No
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items Z8a or Z8a-f show any injury or other traumatic event, the Medical Examiner must be notified at once		11. Marital Status 1 ☐ Never Marrie 3 🏝 Widowed		12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	?		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 🛣 No	an, Mexica	ın, Puerto	ecify Yes or No Rican, etc.)	-		ck, White,	can Indian, etc. nite
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Page 1 a ment of H ant: If ite ury or otl		20a. Method of Disp 1 🏖 Burial 2 Ū 4 □ Donation	Cremation 3	3 ☐ Removal from Starecify)	te Sp	Place of Disponentery, cremetery,	sition (Name of natory or other place II Memory ens	y Y		Date 4/10			- City or Ton	own, State
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Physician/			ne disease, or c t failure. List on Final	omplications that caus ly one cause on each li								-		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	1	Due to (or a	s a consequ	uence of):								
uted d ansit	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying injury	Due to (or a	s a consequ	uence of):								
ite be executed hysician and he burial-transit		that initiated events resulting in death) L		Due to (or a	r as a consequence of):									
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. within 24 hours after death. within Exhancal infector. After this certificate has been signed by the attending physical completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknowr	n 2 ☐ Feta at time of d	aldeath 3 [Ectopic pregnand Other (specify)	су					ate of delive	very Day Year
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In the hospital or Attending Physician: In the Punral after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2	Medical Ex	Physician: To the best of aminer: On the basis of turse Practioner: To the	examination	n and/or inves	tigation, in my opini	on, death o	occurred a	t the time, date	and place	ce, and du	ie to the ca	ause(s) and manner stated.
vithi Comp		29b. Signature and t	title of certifier	Law	7	asi	29c. Licens	e number	515		29d. D	ate signe	d (Month,	Day, Year)
The		30. Name and addre	ess of person w	ho completed cause of	death (Item		Print) NSHOR	e D	p	SALISP	BUR	Y 1	MD	21804
Stat		31. Date filed (Month	Day, Year)	2010 32. Fegis	trar's Signa		and							

DHMH 17 Rev 7/2009

Amend #11,15, & 16a, per FH g902 4/23/10 TT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-02416 State of Maryland / Department of Health and Mental Hygiene Michael Douglas Smith Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1655 hrs Michael Smith March 26, 2010 ুবাcal Examine Douglas 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Allegany Corriganville CSX railroad tracks at mile marker BF182.1 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number Funeral oreign Country MD Days Months 216-90-5184 42 Aug 21, 1967 Director 2 F Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 10a. State 10b. County 1 X Yes 2 No MD Corriganville Allegany or items 23a or 28a-f sho must be notified at once hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13507 Jennings Way 21524 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funera 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 Married 2 X No white Yes Specify: 1 Yes 2 No specify: If Yes, Give Year 3 Widowed 4 X Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Respiratory Therapist 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) be filed within 72 traumatic event, the Medical 21215-0036 12 Nursing Home maintenance permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Kreger Mitzie (Sachs) Bowman Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mother 17806 Green Tree Ter. MD 21740 Mitzie Bowman Hagerstown 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition timore, crematory or other place)
Scarpelli Funeral Home, P.A 1 Burial 2 X Cremation 3 Removal from State 3/28/2010 MD Cresaptown 4 Donation 5 Other Specify 9 22. Name and Address of Facility Scarpelli Funeral Home, PA 21 igna re of Funeral Se 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Part I. Enter the diseas. // complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Retween Onset and Death /Medical Multiple injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical #2/ & 28d, per ME g902 4/21/10 TT AMENDED #2/ 23a,27,28a-f,permE, X UNPENDED ed by the attending physician detached for use as the burial g902 The law requires that the death certificate be O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? signed by t be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ģ 1 Yes 2 No 3 Probably 4 Unknown Records, P. Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No page certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death
To the Funeral Director: After this certifi 25. Was case referred to medical of Vital Be Other Nursing Home 5 Residence 6 Other Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28d. Describe how injury occurred Subject struct 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? stepped in front of Certification Natural 1 Yes 2 X No Division while trying to avoid train
28f. Location (Street and Number or Rural Route Number, City
or Town, State) CSX tracks
BF182.1 Corriganville, MD Pending 4:45 pm the 3/26/10 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be train tracks (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 27, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}010 April Physician/ 7:56 PM M Cinda Gale Spencer 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Northampton Manor Health Care If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Hours Min. 1 M 2 X 8 Manth 12945 MD Director 216-76-6193 64 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 No Frederick Frederick MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 901 Young Place 21701 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White If Yes Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) N/A College (1-4 or 5+) Retail Goodwill Industries Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Eva Nugent William Spencer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2090 Old Farm Drive 1E Frederick, MD 21702 P/R Dawn Ann Bambrick 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory 4-10-2010 4 Donation 5 Other (Specify) Smithsburg, Maryland Reeney and Eastord PA Funeral Home 106 East Church St., Frederick, MD 101176 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death () ISEASE Immediate Cause (Final Schenosi AMERY 7 Heno Physician Medical resulting in death) Due to (or as a consequence of) Examiner BIRTY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year 5 Other (specify) Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 2 perform 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: 2 မှ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one)

State Registrar

Sh

FREDERICK

Hame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

A

31. Date filed (Month, Day, Year)

10-02235 Harry Lee Taylor, II	aylor, II State of Maryland / Department of Health and Mental Hygiene												
	R	- For State egistrar	-			ite of Dea			Re	eg. No. 2010	10732		
Physician/ Medical Examine	1	Decedent's Name (First, Middle, L Harry Lee Taylor							2. Date of Deat Month March 19,		3. Time of Death 1740 hrs		
E .		4a. Facility Name (if not institution, 1094 Broadwater Point	give street and number)				Town, or Loca	ition of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4c. County of Death			
Funeral				e (In yrs. I	ast birth			Under 24Hrs.	8. Date of Bir	th(MM/DD/YYYY) 9. Birt	hplace (State or		
Director	-	577-46-6259	X _M 2_F	76		Yrs. Mont	hs Days I	Hours Min.	02/05/	1934 Foreig	nWasilligton, DC		
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town	or Location					10d. Inside City Limits		
*	5	Maryland Anne A	Arundel			hurchto	n				1 Yes 2 No		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland and the filed within 40 hours after death with the Maryland fant: If liem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		10e. Street and Number 1094 Broadwater	Doint Dood			10f. Zi	20733		1	Og. Citizen of What Cour	og. Citizen of What Country? United States		
with the 1s 23a se notil		11. Marital Status	12. Was Decedent	Ever in U	.S.	13. Was Deced	ent of Hispani			- 14. Race - Ameri	can Indian, Black,		
r death with or items 23 must be no	3	1 Never Married 2 Marr	1 1 Yes 2	No			ify Cuban, Me		Rican, etc.)	White, etc.	4.6-		
ural",	<u>-</u>	3 Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates: y only highest grade cor			1 Yes 2			vork done	Specify: W.T. 16b. Kind of Business/I	nite Industry		
72 hourn al Exam		Elementary/Secondary (0-12)	College (1-4 or		(during most of wo	orking life. DO	ng life. DO NOT use retired)					
5-0036 led within 7 Hygiene. other than the Medica		7. Fallenda Nama (First Adiable)	4		Se	1f Empl		lathar's Nama	/First Middle 1	General Cor Maiden Surname)	itractor		
21215-0036 21215-0036 21d be filed within 7 Mental Hygiene. marked other than ic event, the Medica	5 2 F	17. Father's Name (First, Middie, La Harry L. Taylor	ast)						ie Owen	valden Sumame)			
212 tould b and Meni is marl tic ever	• L	19a. Informant's Name/Relationship								nber, City or Town, State			
MC 2 sl und 2 sl aalth an	ŀ	Georgene A. Tay.	lor/Wife	20b		194 Broa f Disposition (Na			Road, C	Churchton, M			
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and Important: If Irem 27 is m injury or other traumatic.	1	1 Burial 2 Cremation	3 Removal from St	ate	cremate	ory or other place	9)		25/2010	Waldorf, Ma			
altin mit. P: partme portan ury or	-	4 Donation 5 Other Spec 21. Signature of June 12/Specice Lie	censee	C 111	шсу	22. Name an	d Address of F	acility eol	ge F. K	alas Funera	I liome		
	1	23a. Part I. Enter the disease, or co			Edgewater,	MD 21037 Approximate Interval							
Physician /Medical	g	failure. List only one cause or Immediate Cause (Final disease								est, shook, of fleat	Between Onset and Death		
aminer	1	or condition resulting in death)	Due to (or as a cons										
in the second		Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause C.											
ted Insit Examiner		(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence o	of):								
execultion and the train and t		X UNPENDED	AMENDED 23a, 2	7 . ne	rmE.	, g902 4	/16/10	тт					
68760, certificate be unding physicis	2	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outco	me of preg	nancy	Fetal death		ctopic pregna	ancy	23d. Date of delivery	/ Day Year		
Box 68760, the death certificate be the attending physic the attending physic tentor is at the burner of for use as the burner thy signification (Medician) Medician (past 12 months?	4 Pregnant a	t time of de	eath 5	=		ctopic pregne		Worth	7.0,		
). Bc the dear the dear ched fo	Ě	Part II. Other significant condition	9 Ulikilowii	h but not r	resulting	in the underlyir	ng cause giver	in Part I.	23e. Did to	obacco use contribute to	the cause of death?		
ires that the signed by 1 lbe detached	3				_	,			1 Yes	s 2 No 3 Prot	pably 4 Unknown		
Records, The law require. ficate has been signage 2 should be									24a. Was autor	osy prior to o	topsy findings available completion of cause of		
tal Records inn: The law requirentificate has been ectrificate has been ector, page 2 should Be Complete	[1 ✓ Yes	rmed? death? 2 No 1 ✓ Ye	es 2 No		
ital ician: s certifi rector,	8	25. Was case referred to medical examiner?	Hospital:	ent 2] ER/O	utpatient 3	26.Place of DOA	Death (Check	only one)	Residence 6 ✓ Othe	r Scene		
ing Physi ing Physi After this uneral dir	- 1	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inj (Month, Day,			Time of Injury	28c. Injury at			how injury occurred			
ion trendin death. fort A	<u> </u>	1 X Natural 5 Pendin 2 Accident Investig	g gation					2 No					
Division of Vital Records, P.O spital or Attending Physician: The law requires that thours after death. Incred Director. After this certificate has been signed by filled in by the funeral director, page 2 should be detacted in by the funeral or Decompleted by I		3 Suicide 6 Could determ	not be	njury - At h	iome, fa	rm, street, facto	ry, office build	ing, etc.	28f, Location (or Town, \$	Street and Number or Ru State)	ral Route Number, City		
Division of Vital Records, P.O. B. To the Hospital or Attending Physician: The law requires that the d within 24 hours after death. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Medical Certification: To Re Completed by Physician 10 of the physician of the		29a. Certifier 1 Certifying Phy	sician: To the best of n iner:On the basis of exa and manner stated	ny knowled amination a	dge, dea and/or i	ath occurred at the nivestigation, in r	ne time, date a ny opinion, de	and place, and ath occurred a	I due to the cau at the time, date	se(s) and manner as stat and place, and due to th	ed. e cause(s)		
T W I W		29b. Signature and title of certifier	and mainer stated	/		2	9c. License nu			29d. Date signed (Mo	nth, Day, Year)		
	-	30. Name and address of person w	horsarta	HOTTE	1 23a)	D	O.C.M.E	= .		March 20, 2010			
			Assistant Medica	I Exami	ner	111 Penn S	treet, Baltii	more, MD	21201		CME		
Stat Registra		31. Date filed (Month, Day, Year)	2010 32. Registr	ar's Signat	ure	Barce	0						

10-02273 Raymond Valdez			pe or Print i tate of Maryla	and / Depa		f Heal	th and				20	10 1073			
Physicia Medical Exami	ın/	Decedent's Name (First, Midd Raymond Valde							2. Date of Month		Day Year	3. Time of Death 0324 hrs			
		4a. Facility Name (if not institution 9208 Stream View La	on, give street and no	umber)		4b. City, T		Location of I			4c. County of D	eath			
Funeral		Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)		er 1 Year	f If Under 2	24Hrs. 8. Date	of Birth(MM/DD/YYYY) 9	. Birthplace (State or			
Director		464-08-9268	1 M 2 F	5	8 Yrs	Month i.	s Days	Hours	Min. Febr	ary/	21, 1952	Country)Texas			
yns		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat	tion						10d. Inside City Limits			
*	ъ	Maryland Howard	E	La	urel			_				1 Yes 2 X No			
e Maryl or 28a-f	Director	10e. Street and Number 9208 Stream V	iow Lane			10f. Zip	Code 0723			10g.	. Citizen of What USA	Country?			
death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status	12. Was De	cedent Ever in U.		as Decede	ent of His		? (Specify Yes		14. Race - A	merican Indian, Black,			
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-003 I within giene. Iher the	Completed	17. Father's Name (First, Middle			Conti	racto		18.Mother's	Name (First, Mi		iden Surname)	of Energy			
b, MD 21215-0036 and 2 should be filed within 72 hours after fealth and Mental Hygiene. item 27 is marked other than "natural", traumatic event, the Medical Examiner.	Be	Evaristo Vald						Feli	pa Alva	rado					
MD 21 d 2 should tht and Me n 27 is ma	ဍ	19a. Informant's Name/Relation Paula G. Vald			10.0	-	•				er, City or Town, S , MD 207				
e, M I and 2 Health item 2	Н	20a. Method of Disposition		I	Place of Dispos	sition (Nar	ne of cer	metery	Date	12	20c. Location - Cit				
imore Pages I nent of F		1 Burial 2 Cremation 4 Donation 5 Other S		Tom State	te of Hea			ery	March 26 2010	·'	Silver Spr	ring, Maryland			
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Cigneture of Funeral Service			F	ranci	is J	. Coll	ins Fur	nera]	l Home,	Inc.			
Physician	-			caused the death	Do not enter t	00 Ur	nive: of dying,	rsity such as car	Blvd., diac or respirate	W., ory arrest	Silver t, shock, or heart	Approximate Interval			
/Modical Examiner	10	Immediate Cause (Final diseas	Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 209 3a. Part I. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. mediate Cause (Final disease a, Atherosclerotic Cardiovascular Disease												
No		failure. List only one cause on each line.													
	iner	if any, leading to immediate cause. Enter Underlying Cause		a consequence o	f):										
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence o	f):										
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760, icate be physic the bur	/Med	IF FEMALE: 23b. Was decedent pregnant in	the	, outcome of preg							23d. Date of de Month	livery Day Year			
Box 68760, cath certificate be executhe attending physician and office use as the burial - Ira	ician	past 12 months?	4 Preg	ριπη nant at time of de	oth _	etal death ther (Spe		Ectopic p	pregnancy		Month	Day Teal			
b. Bo the deal	Physician/Medical	Part II. Other significant cond	nknown 9 Unkr		esulting in the	underlying	g cause g	given in Part	I. 23e	Did toba	acco use contribu	te to the cause of death?			
P.O. ires that the signed by it be detach	þ									Yes	2 No 3	Probably 4 V Unknown			
cords, law requii has been s	plete								24a	Was an autopsy	, prio	re autopsy findings available r to completion of cause of			
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n of ving Phy	-	27. Manner of Death	28a. Dat (Mon	e of Injury th, Day,Year)	28b. Time of	Injury		ry at Work?		cribe ho	w injury occurred				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execuvithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra		29a. Certifier 1 CertifyIng I	Physician: To the be												
	Medical	29b. Signature and title of certif	and manner		androi investiga			se number				(Month, Day, Year)			
12+1		The day	m. Ki	e/TP	m. 7		O.C.	M.E.	OCME		March 21, 20	10			
		30. Name and address of person Theodore M. King, Ju		e of death (Iten		111 0	enn St	reet Ralt	imore, MD 2	1201					
S	tate		2010 337	Registrar's Signat		Ke									
Regis	trar	P & JHM	2010 Cle	were f	. par	The									

DHMH 17 Rev 1/2001 TH

State Registrar Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

CRUP 14014 Marsh

29d. Date signed, (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ . 20<u>10</u> March 20, Stuart Glover Whitehurst 3:30 A M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crumland Farms Health Center Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 6. Sex 7. Age (In vrs. last birthday) Funeral 8. Date of Birth Months Days Hours Min (Month, Day, 1 ☒ M 2 ☐ F 229-14-9766 Director 88 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Frederick ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a7407 Willow Road, Suite 252 21702 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗌 No Black, White, etc. "natural", or 2 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced WWII the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Federal Government Be permit. Page 1 and 2 should be filed Department of Heatth and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Royal H. Whitehurst Ethel Glover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Whitehurst / Wife 7407 Willow Rd., Ste. 252, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State March 27, 1 X Burial 2 Cremation 3 Removal from State Other (Specify) 4 Donation 2010 Frederick, Maryland Signature Funeral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwv. Frederick, MD 21701 23a. Part 1. Fater the shock, or heart sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ure. List only one cause on each line. Immediate Cause (F disease or condition resulting in death) Onset and Death CORONARY Physician/ HEART DISEASE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year signed by the at d be detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No 1 Yes Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certific. completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) hon DZ1936 3/22/2010 MD

3+1VA

State

Registrar
DHMH 17 Rev 7/2009

JOHNSON DR, FREDERICK, MB 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65C

THOMAS

82. Registrar's Signature

A. DONELSON

31. Date filed (Month, Day, Year) MAR 2 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Robert Edward Walberg 2010 March 17, 0300 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) 1 M 2 □ F Director 392-22-7593 83 Jan 18. 1927 Wisconsin Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show ust be notified at 1 □Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. In the Mer 21 is marked other than "natural", or items 23a or mut: If the Medical Example cause but nry or other traumatic event, the Medical Example cause but. 1003 Cherrytown Rd. 21158 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆ Yes 2 □ No 194 If Yes, Give Year or Dates: 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. 1 ☐ Never Married 2 ☐ Married 1945 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 XWidowed 4 ☐ Divorced 1946 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Baltimore Gas College (1-4or 5+) Foreman and Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Albert Carl Walberg Alice Otillia Olson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Walberg 2803 Coldstream Dr. Tallahassee, FL 32312 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 3/19/2010 | Hampstead, Maryland 21. Signature of Funeral September 21. 22. Name and Address of Facilit Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Stage Frad disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical signed by the attending p be detached for use as IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 No cate has been si page 2 should t 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate 2 No 1 ☐Yes To the Hospital or Attending Physiclan: "
within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) No. Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \times Other (Specify) 1∏Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural

2 Accident 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) My somerago

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

MAR 1 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

M. ANSURITA 349 Mallow M. Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 22 Day 2010 Year Physician/ Richard Frederick Wendel 6:17 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kent Chester River Manor Chestertown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Apr. 29, Year 930 Il Timois Director 335-24-4778 79 Usual Residence of Decedent 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🙀 Yes 2 🗌 No Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21620 USA 06 South Oueen Street 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify:White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ College Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer C. Wendel Victoria Jeffrev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Travis Wendel/ Wife 106 South Queen Street Chestertown, Maryland 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Cntr. 3/23 Stevensville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 30 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on such line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exam the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the a d be detached f g 🗌 Unknown g 🔲 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen FISRI4LETM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to dical Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 🗌 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Centifying Nunce Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar Signature and title of

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

+ mi

10

29c. License number

29d. Date signed (Month, Day, Year)

120 Speer Rd. Chestertown, MD 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20, 2010 ear John Alden Walker 10:05P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5851 Coleman Rd. Rock Hall Kent Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days 1 □XM 2 □ F Months Hours 7/16/1940 **Director** 179-32-1369 69 PA Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD 1 Yes 2 X No Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5851 Coleman Rd. 21661 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Was Decedent 2.5. Armed Forces? 1X☐ Yes 2 ☐ No 1959-Black, White, etc. , o þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White "natural" 3 Widowed 4 Divorced Specify: Completed 1965 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic secret. Elementary/Seconday (0-12) College (1-4 or 5+) 12 HVAC Tech HVAC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည James M. Walker, Sr. Arline Alden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5851 Coleman Rd. Rock Hall, MD 21661 Betty Lou Walker/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 3/22/10 Stevensville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Fellows, Heltenbein & Newnam Funeral Home Kuk 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ una disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by Melavona 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 25. Was case referred to medical Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manpar of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending To the Hospital or Attendin.
within 24 hours after death.
To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 10064388 3/22/. Chartertown, MD 2(620 10+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ms State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day March 16, Clarence Levine Zepp 2010 2215 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours 1 ☑ M 2 □ F 88 7, 1921 Maryland 217-18-7913 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3064 Littlestown Pike 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 科 Ses 2 □ No 1944 If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 Divorced 1945 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Press Operator Beacon Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence A. Zepp Rachel E. Devilbiss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife 3064 Littlestown Pike Westminster, MD 21158 Mary M. Zepp 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 3/20/2010 | Pleasant Valley, MD Pleasant Valley Cem 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service License 412 Washington Rd. Westminster MD Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final End 31110-3/16/2 04 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □Ne 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, It a Medical Examinar must be notified at

Health and Mental Hygiene. em 27 Is marked other than ther traumatic event, II = M

permit. Pages 1 and 3 Department of Health Important; If item 27 any injury or other troones.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

þ

Completed

Be ပ္ MD

Examine burial-trar

Physician/Medical \$ Completed Be Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician for use as the buria certificate has been signed by the rector, page 2 should be detached after death.

Director: After this certific

J in by the funeral director,

Division of Vital Records, P.O. Box 68760,

To the Hospital or within 24 hours aft To the Funeral Di completely filled in WAIOT IVA State

29b. Signature and title of certifier

29c. License number

1 ☐Yes 2 ☐No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify)

28d. Describe how injury occurred

Hospital:

5 Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

1 Yes 2 Ne

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide



1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 50 rancis 10 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ole HUND lelag rapk HENOURK If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MT 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 🗆 F Hours Min. Dec. 22, 1922 87 215-16-2684 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If feem 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Hanover Anne Arundel 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 7548 Old Telegraph 21076 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' Black, White, etc. þ 1 Never Married 2 Married X Yes Yes, Give 2 🗆 No 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Chemical/Electronics Lab Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Arnreich, Sr. Alma Marcks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1316 Bartley Place Belcamp, MD 21017 Mr. John F. Arnreich III/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets Cem. 2010 Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Leter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. interval Between Immediate Cause (Final Vascular Derkex Onset and Death Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 10 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural To the Hospitallor Attending within 24 hours feer death.

To the Funeral prector Afticompleted filled in by the fun 1 Yes 2 No 🖺 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A Kalle

CKWP

3 Kcertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

noch Russon Blod

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10. 48M Romnie ApH 20/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Secours Ba Baltimore City TIM. Dre 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 52 Yrs. If Under 8. Date of Birth **Funeral** Country)
Maryland 1 🛛 M 2 🗆 F Months Days Hours Min 1072171957 216-66-8288 **Director** Usual Residence of Decedent should be filed within restronce. In and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show its marked other than "dical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Baltimore City Baltimore City 1 X Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 21214-1832 6203 Carter Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 【X No Black, White, etc. 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Cabinet Installer 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Edward Johnson Ashford Mary Louise Ferley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sandra Ashford / 6203 Carter Ave, Baltimøre, MD 21214 spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State West Chester, 5 Offjer (Specify) 4/7/201/0 4 Donation Ferris & Co. Pennsylvania 21. Signature of the ar Tarring-Cargo 333 S. Parke Funeral Home, P.A. St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Myocardial acute disease or condition resulting in death) minnta Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. Examine cause (Disease or iinjury Duri to for as a consecuence attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death signed by the a g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XJnknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No cate has page 2 s 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 No ဂ္ 1 Inpatient 2 FR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending Division 1 Yes Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier mergency ar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 N. Baltimon. Ofrect Marga Cort, m) Sanys HOSPITAL 31. Date filed (Month, Day, Year) State 32. Registrar's S APR 08

DHMH 17 Rev 7/2009

Registrar

10-02650 Cynthia Askew

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 10743 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 0757 hrs April 5, 2010 Askew Medical Examiner Cvnthia May 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie **Baltimore Washington Medical Center** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number Funeral Foreign Maryland Months Days Hours 01-26-1962 Director 2XXF 48 212-72-8525 1 ☐ M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 10b. County 1 Yes 2 XXNo Anne Arundel Glen Burnie s 23a or 28a-f show e notified at once. MD 28a-f show death with the Maryland Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 IISA 440 Gatewood Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X X No White f Yes, Give Year Yes 2 V No specify: Specify: Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "matural", of
injury or other traumatic event, the Medical Examiner. 3 Widowed 4 Divorced δ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Cleaner 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Jane Thompson Edwin Askew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ellicott City, MD 21043 Betty Askew (mother) 5408 Autumn Field Ct. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 4-9-2010 1 X Burial 2 Cremation 3 Removal from State Elkridge, Maryland Meadowridge Memorial Park 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Surfature of Funeral Service Licensee L. Kaufman Funeral Home a Washington Blvd. Elkridge Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ast only one cause on each line. Approximate Interval Physician Between Onset and (Medica) Death a Pulraonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last by the attending physician and ached for use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 __ Other (Specify) 1 Yes 2 V No 9 Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available 24a. Was ar has been autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes After this certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 🗸 Natural Yes 2 No hours after death.
uneral Director: A Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined (Specify) 24 hours Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 6, 2010 O.C.M.E. 8 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day Year) APR 08 State arke

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 7:58PM Physician ichae 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** N/A The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign of Columnia) If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe . Age (In vrs. last birthday) **Funeral** Days Hours Min June 4, 40 1969 **Director** 213-88-5181 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Crofton Maryland Anne Arundel 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 2501 Vineyard Lane United States 21114 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 Yes 2 No þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (54 or 5+) IT Specialist Computer Support 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Pages 1 and 2 should be fill ment of Health and Mental Hiant; If item 27 is marked oth Be Richard W. Blackman Nina G. Bartley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard W. Blackman/ Father South Carolina 29803 204 Winged Elm Circle, Aiken, Department of Healt Important: If item 2 any injury or other once. 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2010 Metro Crematory, Inc Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Ma<u>ryla</u>nd 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EM3 **Physician** disease or condition resulting in death) /Medical Due to (or as a con uence of) **Examiner** Sequentially list conditions, if any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directly for as a consequence of attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Tectopic pregnancy ☐ Pregnant at time of death☐ Unknown Month Day Year in the past 12 months? 5 Other (specify) 2 No the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 2 1 🗌 Yes 2 No or Attending Physician: funeral director. 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) \(\frac{5 \(\text{D Residence} \)}{2 \(\text{Residence} \) 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ this 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Yes 2 No death. completely filled in by the 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 010

State Registrar Benjamin Steinberg

31. Date filed (Month, Day, Year)

32. Repatrack Signal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month APIZZL Physician/ ARIE 120TER 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BURNZE ANNE GIER WASHINGTON MEDICAL CONTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, Social Security Number 1 □ M 2 🔀 F Months Days Hours 1072671916 93 213-20-8595 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 XNo Glen Burnie MD Anne Arundel 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21060 U.S.A. 311 Phelps Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) C & P Telephone Clerical Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stella Pucklis Alexander Puszaitis 19a. Informant's Name/Relationship (Type, Print) sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21227 Miss Helen S. Puszaitis / 2806 New York Avenue, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 4/12/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD 21. Signature of Funeral Service Licenses Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Soter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) DATK

Physician Medical Examiner

Funeral

Director

shov

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

burial-tran

attending physician for use as the burial

been signed k should be deta

has

certificate

To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completed filled in by the funeral dire

that the death certificate be Box

Division of Vital Records, P.O.

or Attending Physician:

Physician/Medical Examine 2 Completed

He zhane

MU.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

.1		ACULE HEAD	21	HILLERE			7.10
	Esquentiary list concidents, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence of):	CARI.	DZAL ZNEHA	CTZO	, N	DATS
	that initiated events resulting in death) Last	Due to (or as a consequence of): d SEVERE ADRIZA					YEARS
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	_	ic pregnancy		23d. Date of d Month	lelivery Day Year
	Part II. Other significant conditions of	contributing to death but not resulting in the	underlyir	ng cause given in Part I.	200. 2.2	tobacco use contribute	to the cause of death? Probably 4 1 Unknown
					perf	opsy prior to formed? death?	autopsy findings available completion of cause of es 2 \square No
,	25. Was case referred to medical			26. Place of Death (Chec	k only one)		
)	examiner? 1 Yes 2 No	Hospital: 1 XInpatient 2 ☐ ER/Outpat	ient 3 🗆	DOA Other: 4 Nursing H	ome 5 🗆 Res	idence 6 Other (Spe	ecify)
	27. Manner of Death 1 M Natural 5 □ Pending 2 □ Accident Investigatio	28a. Date of injury (Month, Day, Year) 28b. Time injury	of	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurred	
	3 Suicide 6 Could not be 4 Homicide determined		street, fact	tory, office	28f. Location City or To	(Street and Number or F wn, State)	Rural Route Number,
	Chack of Medical Exam	vician: To the best of my knowledge, deat niner: On the basis of examination and/or inv rse Practioner: To the best of my knowledge	estigation.	in my opinion, death occurred a	at the time, date	and place, and due to the	e cause(s) and manner state
	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mor	

BALTIMORE WASHINGTON MEDICAL CENTER, 300 HOSPITALDRIVE, GLENBURNEE, MD. 21061

April.06, 2010

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 3:00AM Shirley Borden March Newman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2 Shaded Glen Court Owings Mills If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Months 1 □ M 2 💢 F 05/19/1919 Maryland Director 90 216-03-3386 Usual Residence of Decedent and 2 should be filed within and Abrilla and Abrilla and Mental Hygien and Mental Hygien 27 is marked other than "natural", or items 23a or 28s and item 27 is marked other than "natural", or items 23a or 28s and item 27 is marked other than "natural", or items 23a or 28s and items 27 is marked other than "natural", or items 23a or 28s and items 27 is marked other than "natural", or items 23a or 28s and items 27 is marked other than "natural", or items 23a or 28s and items 27 is marked other than "natural", or items 23a or 28s and items 23 o or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Shaded Glen Court 21117 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Education Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Filenberg Newman Annette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Borden / Daughter 2 Shaded Glen Court, Owings Mills, MD 21117 Department of Health Important: If item 2 any injury or other t injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗖 Cremation 3 🗖 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 03/31/2010 Hanover, Maryland Signature of Fundal Service Lightsee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate base. Enter underlying Cause (Disease or linjury Due to (or as a consequence of) and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No the g Unknown P.O. I signed by the Part II. <mark>Other significant conditions</mark> contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title n 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

APR 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Apr 4, 2010 Physician/ Willis Edward Boswell 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia **Brighton Gardens of Columbia** 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 🗆 (Month, Day, Year) MD Director 577-03-9593 1093 Jun 13. 0916 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7110 Minstrel Way 21045 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian . Marital Status Armed Forces?

1 Xes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced aul Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) **Certified Public Accountant** Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carl Clifton Boswell Hannah Elizabeth Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2308 Hollowoak Dr. Hanover, MD 21076 Charles Boswell Son permit. Page 1 and 2 Department of Healt Important: If item 2 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Apr 17, 2010 Westminster, MD **Meadow Branch Cemetery** naturo of Funeral 22. Name and Address of Facility any Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1 Enter the disease, or complications in t caused the death, shock, or heart failure. List only one car's a cach line. Do not enter, the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betwee Immediate Cause (Final disease or condition resulting in death) Ph_sician/ Medical Due to lor as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 2 X No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performa this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State		State of	Maryla	nd / Depa	artmen rtificate				ntal Hy	,	2010	1071.8
		Registrar 1. Decedent's Name (First,	Middle, Las	t)			inout		Joann		. Date of De	Reg. No		3. Time of Death
Physiciar /Medica		Vera W. I	Bryan								Month	Day	2010	2:28 PM
Examine	er	4a. Facility Name (If not ins			nber)	1	4b. City,	Town, or	Location of	of Death		4c.	County of Death	
gar de			Squa		05/11/	2	If Under	<u>-05</u>	eda	le			13altin	lore
Funeral		5. Social Security Number	6. Se	ex □M.2×vFkF	0 , ,	s. last birthday) Yrs.	Months	Days	If Under Hours	Min.	Date of Bir (Month, Di	ay, Year)	Cour	
Director		213-28-7280 Usual Residence of Decede		nn _	100) 110.]1.	1-15-1	1909	Kentu	cky
land ow	1	10a. State 10b. C			10c. C	City, Town or Lo	cation						1	0d. Inside City Limits
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r 288	Director	10e. Street and Number	Jar Cris	.010			10f. Zip		<u></u>			10g. Citi	zen of What Cour	itry?
h with		1215 Fourth F	Coad					21220	0			Uni	ted Stat	es
deat	Funeral	11. Marital Status		12. Was Dece		U.S. 13.			_	igin? (Speci	fy Yes or No		14. Race - Americ	an Indian,
after or its		1 Never Married 2	Married	1 Tes	2 🔼 No		ires, spec 1 ⊟Yes 2		Specify:		an, etc.)		Black, White, e	
ours Linality	d by	3xxWidowed 4 □ Div	orced	Year or Da	ites:			X 110	opoony.				Specify: Cau	casian
21215-0036 21215-0036 a within 72 hours aft giene. r than "natural" or if the Predict Every	Completed	15. Dei (Specify only	cedent's Ed highest grad	ucation de completed)		(Give	dent's Usua kind of wor	k done c	durina mos	t of working		16b. Ki	nd of Business/Inc	dustry
12.	Ē.	Elementary/Secondary (0	-12)	College (1-	4or 5+)	iiie.	DO NOT us		*				O II	
and 21215-0036 and 21215-0036 the filed within 72 hours after death with the Maryland antal Hygiene. ed other than "natural" or items 23a or 28a-f show a event, the Medical Examinar must be notified at	ပ္သ	17. Father's Name (First, M	iddle Last)				п	mema	aker	er's Name (F	First. Middle	. Maiden	Own Ho	me
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≥ 9€ 5 =		Nancy C. Wund			r		-						and 2122	•
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If then 27 i any injury or other fr		20a. Method of Disposition			20b.	Place of Dispo				Date			cation - City or To	
Morror Pages nent of inty or o		1 🔀 Burial 2 🔲 Crema 4 🗆 Donation 5 🗎 Ott			otate i					04-08-	-2010	F11	ridge, M	arvland
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Bal permi Depar Impor any ir		Haut	13.li	Stobal	uni)									MD 21075
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/Medical		resulting in death)		a. Tue to (c	or s a conse	-	1 4	HU	10				22 2	
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oertific	/Me	IF FEMALE:		23c. If yes, outo	come of pregr	nancy							204 Data at Lat	
Box eath cert attendin	cian	23b. Was decedent pregna in the past 12 months'	III.	1 Live b	irth 2 Fet	tal death 3 [Ectopic pr Other (sp		У				23d. Date of delive Month	Day Year
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Division of Vital Records, P.O. Box 6 or or Attending Physician: The law requires that the death certificate has been signed by the attending bir by the funeral director, page 2 should be detached for use as		Part II. Other significant co	nditions co	ontributing to de	ath but not re	sulting in the u	nderlying ca	use give	en in Part I.		23e. Did	tobacco u	se contribute to th	ne cause of death?
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ng Ph ng Ph neral	<u> </u>	27. Manner of Death 1 X Natural 5 ☐ F	landing	28a. Date o	of Injury h, Day, Year)	28b. Time of Injury	2	Bc. Injury Work			d. Describe			,,
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Divis lor Atta after de Directe d in by th			ould not be etermined	28e. Place	of Injury - At I	home, farm, str	eet, factory,	office		281	Location (Street an	d Number or Rura	l Route Number,
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Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 15 Ce (Check only one) 2 Me	rtîfying Phy dical Exam	sician: To the liner: On the ba	isis of examir	nowledge, deatl nation and/or in	occurred vestigation,	at the tin in my o	ne, date ar pinion, dea	nd place, an ath occurred	d due to the at the time	e cause(s) , date and	and manner as s place, and due to	tated. the cause(s)
To the vithin Sompl	Z	29b. Signature and title of c	ertifier				29c	License	e number			29d. Dat	e signed (Month,	Day, Year)
		▶ Mall	Kel	Cet M	D		[2000	6968	4		4	104/10	
	-	30. Name and address of pe	erson who c	empleted cause	of death (Ite	em 23a) (Type,	Print)		•		. 4	,	,	
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		Funeral Director		5. Social Security Number 217-40-581 Usual Residence of Decede	75 6. Sex	7. Age	(In yrs. last bird	Yrs. Months		lours Min.	8. Date of Bir (Month, Da	1944	Coun	HD
		aryland show	7	10a. State 10b. C	County		10c. City, Town	or Location					10	0d. Inside City Limits 1 ✓ es 2 □ No
		the Ma	Director	10e. Street and Number			Day	# 100 10f. 2	ip Code			10g. Citizen of W	hat Coun	
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3	aryl	should and Mer is marke aumatic	유	19a. Informant's Name/Re	elationship (Typ	ne. Printi (W.F	19b	. Mailing Addre	ss (Street and	Number or Rura	al Route Numb	per, City or Town,	State, Zip	Code)
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Som	Division	or Atten after deat Director. I in by the	Certification: To	3 ☐ Suicide 6 ☐	Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, fa . <i>(Sp</i> ec <i>ify)</i>	ırm, street, facto	ory, office			(Street and Numb own, State)	er or Run	al Route Number,
	_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	Medical Co	29a. Certifier 1 Check only one)	Zertifying Phys Medical Examir	sician: To the best oner: On the basis of and manner state	examination ar	e, death occurr nd/or investigati	ed at the time, on, in my opin	date and place ion, death occur	, and due to the red at the time	e cause(s) and ma e, date and place,	anner as a	stated. o the cause(s)
		To the within To the compl	Me	29b. Signature and title of	certifier	0_ 5		2	29c. License n			29d. Date signed		
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				30. Name and address of Rima Couzi		mpleted cause of de Joseph Med			Λg1e= 1	Orivo Ci	te.102	Towson	_ MD	. 21204
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 20**1**0 **Physician** 3 11:55 PM EWALD R. BURITSCH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot William Hill Manor Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7 16 1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months Days 1 **™** M 2 □ F Missouri 495 14 8311 88 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State 28a-f show 1 ☐Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shamy Injury or other traumatic event, the Worlan Evan, the country of other permanents. Director Talbot St. Michaels MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21663 U.S.A. Funeral 7964 Oakwood Park Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ⊠Yes 2 No 1939 If Yes, Give Year or Dates: 1959 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No 9 Specify: 3 Widowed 4 Divorced 1959 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) US Post Office Postman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donelli John J. Buritsch Alvina ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Michaels, MD 21663 7964 Oakwood Park Ct Kitridge Buritsch - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Buriat 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem PK 4/7/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home,
160 Piviera Dr. Pasadena, MD 21122 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** section em /Medical Due to (or as a consequence of): Examiner rostatt Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and burial-tran Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 24 hours after death. e Funeral Director: After thi letely filled in by the funeral of 27. Manner of Doth 1 D Natural 2 D Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0

841

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

APR 0 8

31. Date filed (Month

MI

32. Regetrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Mary		artment of F rtificate of I			jiene Reg. No? () ()	10751
			1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medi		William Lehnert			I		March	21 201	
_ }	Examir	er	4a. Facility Name (If not institution, gi				r Location of Death		4c. County of Dea	
I —			209 HItchens Str 5. Social Security Number 6.		In yrs. last birthday)	Ocean If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Worces 9. Bir	thplace (State or Foreign
	Funeral Director			1 M 2 □ F	76 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Jan 17,	1934 Ma	ryland
	yland now		10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
	a-fs	ctor	MD Worces	ter	0cea	n City				1 ☐ Yes 2 ☐ No
	3a or 28	al Director	10e. Street and Number 209 Hitchens St	reet		10f. Zip Code	21842		10g. Citizen of What C USA	ountry?
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be partified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		51-69	1 □Yes 2 🗖 No	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	Specify: W	te, etc. nite
215-	within 72 hiene. than "nati	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of work d)	king	16b. Kind of Business	
21	filed wil Hygien Sther th		12	0	f3	light ele		- (First Middle	milita: Maiden Surname)	СУ
and	t be fill antal H ed ott	Be	17. Father's Name (First, Middle, Las John Thomas	Brown Sr				Dorothy	,	
Mary	1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ther traumatic event, Iru M	ပ္	19a. Informant's Name/Relationship Marlene Brown/s	(Type. Print)	E .	ng Address <i>(Street</i> H itchens		ral Route Numbe	er, City or Town, State,	Zip Code) L842
Baltimore, Maryland	0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 I 4 ☑ Donation 5 ☐ Other (Spec	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - City o	r Town, State
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Foneral Service Lice RODALO S			tare and Addr altimore,			Baltimore	Street
	Physician /Medical Examiner		23a. hart1. Enter the diseas, o con book, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a second b.	e death. Do not en	ter the mode of dyi		or respiratory ar	rest,	Approximate Interval Between Onset and Death
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a d						
.O. Box 6	the death certifiiny the attending proched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand☐ Other (specify) _			23d. Date of d Month	elivery Day Year
rds, P.	quires that n signed build be deta	by	Part II. Other significant conditions	contributing to death but	not resulting in the t	ınderlying cause gi	ven in Part I.			to the cause of death? Probably 4 🗍 Unknown
of Vital Records,	: The law rec cate has bee page 2 shou	Completed						24a. Was autop perfor 1 □ Yes	osy prior to rmed? death?	autopsy findings available o completion of cause of s 2 \Box
Vit	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:		Oti	26. Place of Dea	1.7		
of	Phys r this ral dir	은	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatie	IN 3 DOA	4 LI Nursing H		dence 6 Other (Sp	ecify)
on	ding h. After	tion	1 Natural 5 Pending 2 Accident investigati	(Month, Day,		Wo	rḱ?]Yes 2. □No			
Division	or Atten after deal Director:	Certification:	3 Suicide 6 Could not determine	be 280 Place of Injury	l - At home, farm, st (Specify)	reet, factory, office		28f. Location (5 City or Tox	Street and Number or i vn, State)	Rural Route Number,
_	Hospital 24 hours Funeral stely filled	Medical C	29a. Certifier (Check only one) Certifying I Medical Ex-	Physician: To the best of aminer: On the basis of e	xamination and/or i	th occurred at the to	time, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	Fo the within Fo the comple	Mec	29b. Signature and title of certifier)		29c. Licen			29d. Date signed (Mo	nth, Day, Year)
	1 0		1	/	MID	030	690		Morch 2	6.2010
			30. Name and address of person who	o completed cause of dea	th (Item 23a) (Type	Print) E. Car	roll 57.	501.	550-7	MD
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 8 2010	o completed cause of deal 27 / M. 32. Registrar	s signature park	1		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Virginia Rose Brisebois 2010 April 5:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9600 Trepid Road Nottingham <u>Baltimore</u> Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 💢 F Months Hours Min April 14. Missouri Director 220-36-6938 95 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 ☐xNo Maryland | Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9600 Trepid Road 21236 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: it. Page 1 and 2 should be filed within 72 rooms artment of Health and Mental Hygiene.
sortant: If item 27 is marked other than "natural" "natural", Specify: 3 X Widowed 4 Divorced White Year or Dates. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) years Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Loren Lee Goldman Mary Joseph Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jo Brisebois (daughter) 9600 Trepid Road Nottingham. Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 🌠 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 ☐ Other (Specify) New Cathedral Cemetery 4-10-10 Baltimore, Maryland 21. Signature of Funeral Service Licensee ²² Nitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, 23a. Part 1. Urter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) mon Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by pe □ Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No Yes e referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify, Hospital: s after d atn. al Director: After this co 2 1 No မ 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral C the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cer 2010 30'. Name and address of person who cop cause of death (Item 23a) (Type, Print) OSEMAR OLIVO 31. Date filed (Month, Day, Year)
APR 0 8 2010

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Charles Burgess 8:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Norwest Hospice 5. Social Security Numbe 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 214-12-0312 Months Hours Min. Ap#1129 Director 87 MD Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 😾 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 2355 Flax Terrace 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 😾 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify:Black 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Attendant Northwest Laun N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Burgess Mary A. Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2012 Northern PKWY Baltimore, MD 21215 Rosa Burgess/ Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forrest Page 1 ? Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/12/10 Owings Mills, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beverly D. Cromartie F/S romai 2700 Edmondson Ave. Balto., MD 21223 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Cardiovascular disease Atheroscienotic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a nonsequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 LE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page performed? Yes 2 N After this certificate funeral director, pag 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: in-patient 2 🗹 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director. At completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number MSKajapakseM.D 120057465 4/3/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-203, Baltimore, MD 217.09

DHMH 17 Rev 7/2009

State Registrar S. Rajapaksemio

31. Date filed (Month, Day

2835 Smith AV.,

r's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Danny L. Catlett ¼7¼/201ð³^y 2:30am M Medical Facility Name (if not institution, give street and number)
1469 Towson Street Examiner 4b. City, Town, or Location of Death
Baltimore City 4c. County of Death N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 218-44-4871 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Hours **Director** 63 7/25/1946 WV Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director N/A MD Baltimore City 1 Yes 2 □ No 10e. Street and Number 1469 T 10g. Citizen of What Country? 10f. Zip Code And Mental Hygiene.
marked other than "natural", or items 23a or Towson Street 21230 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? orces? Army ^{2 V}letnam Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: If Yes, Give white 3 Divorced 4 Divorced Specify. Year or Dates. 66-68 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Longshoreman Shipping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin ဂ္ Catlett Mary Margaret 19a. Informant's Name/Relationship (Type, Print)
Betty Lou Catlett / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1469 Towson Street, Baltimore MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 4/ 7/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Onset and Death Physician/ LUNG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Dav Year ☐ Yes ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PUMOHRY NISAJE 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown SLABZIG JAJUSZAV 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 XXX 1 Yes 2 XXo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2XXNo 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred XX Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

BALTIMORY MS 2120

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** lorn well /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner eg se alery lanor lan Cha If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X**M 2□ F Hours 21344 1052 Director 08/01/1945 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ✓ Yes 2 ☐ No y chal permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Heath and Marnell Hygene. Inportant: If item 27 is marked other than "natural" or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified any injury or other traumatic event, the Medical Examiner must be notified. Monta Director 10e. Street and Number 10f. Zip Code Montgonery (our Funeral 14. Face - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: Whit Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Handyman Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fin and Mental H Be Robinson Cornwell ပ Viraie Marv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 111 East Hamaker Street, Thurmont, MD 21788 Anna Kidd / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hanover, Maryland 04/07/2010 Anatomy Gifts Registry 4⊠Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Sign sure Funeral Service Licensee 7522 Connelley Dr., Suite P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer Lung Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner OA death certificate be executed and burial-tra (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ned by the at edetached for ☐Yes 2☐No 9□Unknown 9 Unknown ate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed 2 No 2□ No 1 ☐ Yes 1∐ Yes within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 ☐ Yes 27. Manner of Death 1 ₩ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō Hospital | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Millu Itavding 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 206 Rowelle MD drive 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#8perFH, G902,4/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6^{Day} **Physician** April 20ÎÖ Ruth Marie Casev 9:45A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Carroll County General Hospital Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, April 23, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 482-18-8168 86 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Madical Examiner must be notified at 1 ☐ Yes 2 No Directo Carrol1 Svkesville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1442 Buckhorn Road 21784 U.S.A. by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🕱 No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Servant N.S.A. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marjorie Hofius Claude E. Dearchs 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) North Caroline 28467 568 Montaigne Court N.W. Calabash, Jerry Casey (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-8-2010 Glen Burnie, Maryland Atlantic Crematory 21. Signal of Funeral Service Licenses Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on experience. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RIWARY **Physician** EMENTIA /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar P.O. Box 68760 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months2 Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ NO the detached 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 🖾 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed/Month. Dav. Year) 29b. Signature and title of certifier D 2080G 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 1000 LIBORTY RD ELBORISHURG MD 21784 TRICK CNUS Sulle 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Margaret 04 2010 Clickner 11:50 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Pasadena Home Care Anne Arundel Pasadena Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Hours Min. 03-02-191 Missouri 491-09-1298 Director 97 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Yes 2XXNo Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1226 Stevens Avenue 21227 United States items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner 0. 1 Never Married 2 Married þ 1 Yes 2 K No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2x No Specify. "natural", Specify: White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha 9 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Curry Mary Stock other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael P. Kissel - son 1230 Seven Oaks Road, Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 Burial 2 XXCremation 3 Removal from State Atlantic Crematory 04-08-2010 injury Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Gary L. Kaufman Funeral Home at any MMP., 4 7250 Wash. Blvd., Elkridge, Inc., MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ VPar disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): Exami attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical ital or Attending Physician: The law requires that the death certificate be Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed in director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Records, 2 N 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) 2 NO မ 1 Inpatient 2 ER/Outpatient 3 DOA After this neurs after death.

neral Director After this illed in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 | No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Hos within 24 hours To the Fund Completed 29a. Certifier (Check Gertifying Nurse Practioner: To the best of my knowledge, death occur diet the time, deterand place, and due to the To the aduse(s) and manner as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🛴 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 6, 2010 Vera Louise Carroll April 5:00 A /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year) Harford 117 West Heather Road Be1 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 ▼ F Yrs Director 28, Maryland 218-14-6229 86 Aug. 1923 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the World Experiment, ust by mailthed at 1 ☐ Yes 2 ☐ No Director Marvland | Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" ~- "once. 117 West Heather Road 21014 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ➡ No Specify: þ 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Organist/ Pianist +4Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Ray Musselman Arlene Gertrude Weaver ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry D. Stancill / Daughter 1327 Old Fallston Rd., Fallston, MD 21047 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 4-7-10 Towson, Maryland 21. Signalure Funer Service Licensee 22 Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finai follicula Physician month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off burial-trans requires that the death certificate be execu-P.O. Box 687605 Due to (or as a consequence of): physician a the burial-Physician/Medical as 1 attending properties IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s been signature should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed? 1 □ Yes 2 ☑ No certificate l 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by the

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State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S SIUASACUTM (Suite 200) 32. Registrar's Signatur

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D45530

29d. Date signed (Month, Day, Year)

St Atwood Street, Belair 21014

04-06-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 850 PM 2010 Richard Leroy Cain, Medical بالمحطا 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arunde1 Baltimore Washington Medical Center Glen Burnie 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Months Davs Hours Min. (Month, Day, Year) 05-23-1919 Washington, Director 577-01-4568 90 Usual Residence of Decedent 10b. County 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh t be notified a 1 ☐ Yes 2 X No MDAnne Arundel Severn 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral Examiner must 1914 Champlain Drive 21144 United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. o þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Budget Officer Federal Government Be 17. Father's Name (First, Middle, Last) timore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be Dorothy Danzenbacher John Cain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy C. Mcgee / Daughter 1914 Champlain Drive Severn, Maryland 21144 Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Arundel Crematory 04-07-2010 W. Odenton, Maryland 21. Sign / w of Funeral Service / cense 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 23a Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 50 du Medical Due to (or as a consequence of) Examiner 40 de Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the attending physician and thed for use as the burial-transit that the death certificate be executed ears that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by a completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No Yes 2 🔀 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifier Atlantic Practioner: 29d. Date signed (Month, Day, Year) (Check only one) scon Drive, Suite 20 325 Hometul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21061 31. Date filed (Month, Day, Year) APR 08 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10c Per ANA BDG902 470872010. House All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Day 2010 March 23, **Physician** 5:00 AMM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Baltimore Baltimore Ivy Hall Rehabilitation If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Dec 3, 191 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days 1 ☐ M 2 💢 F Vrs 1915 Maryland Director 215**-**03-6561 94 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Baltimire Baltimore Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21234 2800 A. Upridge Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 🛣 No 3altimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 data entry processor Balto Co public schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Henry Myers ည Mary Ellen Personette 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Whitewood Court Baltimore, MD 21236 Neil Christopher/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Emieral Service Lidensee Wade. State and desaffarboard 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on card failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by funeral director, page 2 should be James 1 Yes 2 No 3. Probably 4 Unknown CTSO 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-38754

State Registrar NASERM.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALICA DASEM. FOG - BASTERN BLVD.

M.D

03-31-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 1243PM Hlice)AWSON 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Ball timore Monroe Street North If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2XXF 218-18-243 **Director** 100 -15-1910 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Directo N/A BALTIMORE MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 807 N. MONROE ST. 21217 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 Specify: BLACK 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSES AIDE HEALTHCARE 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) Be ပ MAMMIE GILMORE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. VICKY WASHINGTON (GRANDDAUGHTER) 807 N. MONROE ST. BALTIMORE, MARYLAND 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Crem ation 3 Removal from State 4 Donation 5 □ 9 ther (Specify) ARBUTUS MEMORIAL PARK 4-5-2010 BALTIMORE, MARYLAND License CONATHAN D. HIBN R2. Name and Address of Facility PHILLIPS FUNERAL HOME.P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death 23a. Par / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final dise of or condition resulting in death) **Physician** ongestil Burs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year 5 Other (specify) 1 ☐Yes 2 ☑No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has birector, page 2 s autopsy performed' 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 1€ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

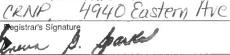
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year, State Registrar

AROL

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)



KO87790

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per verb 2902 4-8-10 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1000 PM 20/0 Medical County of Death (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c lowson If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🗆 M 2 🔏 F Months Days Hours Min (Month, Day, Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 10 No 10 10f. Zip Code 10e. Street and Numbe ö 10g. Citizen of What Country? 23a Funeral items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ō 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Tes 2 No Specify. "natural", Black 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO,NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) မှ Grace Tarro 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number) City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 □ Removal from State ☐ Donation 5 ☐ Other (Specify) em 21. Signature of Funeral Service Liv Name and Address of F any in Eruica 23a. Part 1. Enter the disease, or complications that conshock, or heart failure. List only one cause on sch used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, th line Approximate Interval Between Orset and Death Immediate Cause (Final Physician/ mores mal disease or condition resulting in death) Cours Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 poinths?
1 Yes 2 A No 5 Other (specify) Month Day Year Pregnant at time of death be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform Director: After this certificate Yes 2 No 1 Tes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Deal 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature

Registrar

DHMH 17 Rev 7/2009

State

Ton son, un

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	for State Registrar		Otate of W	ar ylaria / L	Certifica		ath		Reg. No	0010	1076	3
	Physicia	n/	1. Decedent's Name		•					2. Date of De Month		ay Year	3. Time of Death	,
	Medic	al	4a. Facility Name (if n		argaret He	dges Flo		4b. City, Town, or Location of Death				2, 2010 c. County of Death	5:00 P ^M	_
	Examin	er	Ta. I acility Name (ii ii				4b. Cit	Rockville		40	tgomery			
	Funeral		5. Social Security Nur	nber 6. S	ey House 7. Ag	e (In yrs. last birti	hday) If Und Months	er 1 Year If	Under 24 Hrs.	8. Date of Bir (Month, Da		9. Birtl	place (State or Foreign	7
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	a or 2 be no	iO le	10e. Street and Numb				10f. Z	ip Code	•		10g. C	itizen of What Cou	untry?	
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_	filed within 72 hours after death with the Maryland al Hygiene then "natural", or items 23a or 28a-f sho dother than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status1 ☐ Never Marrie	d 2 Married	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 🛣		13. Was Dece If Yes, spe	edent of Hispa ecify Cuban, M	nic Origin? (Spe lexican, Puerto l	cify Yes or No- Rican, etc.)		 Race - Amer Black, White 		
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n D	Depar Impor any ir		Milm	ANTONIO	EthOL +1	40179			eral Home, F Columbia Pil	P.A.	City B	AD 24042		
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	nysician/	1	23a. Part NEnter the disease, or complications hast caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fabure. List only one cause of leach line. Immediate Cause (Final disease or condition											
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X O	eath c atten d for u	Physician/	in the past 12 mg	onths?	1 Live Birth 4 Pregnant a	2 Fetal death	3 Ectopic 5 Other (s					23d. Date of deli- Month	Day Year	
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			Certifying Nurs	se Practioner: To the	best of my knowle	edge, death occ	urred at the tim	ne, date and place	e, and due to the	e cause(s) and manner as s		zU.
	5.≱ 6 8		D Signature and title		1		29	D6063			29d. Da	ate signed (Month,	Day, Year)	
	V		30. Name and address	e of person who o	completed cause of de	eath (Item 23a) (T	ype, Print)	5000.	0 -		17	PIYLI D	MUIU	\dashv
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	Stat Registra	e	31. Date filed Month.	8 2010	32. Registra	r's Signature	del						377 (3	

amend 1 tem 31 per dyr g902 of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tekla A. Feuerhardt Month <u> 20</u>10 4/6 3:30pmMedical 4c. County of Death A 4a. Facility Name (if not institution, give street and number)
Bayview Medical Center **Examiner** Location of Death Baltimore City 4b. City, Town, or Social Security Number 213-70-4173 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 □ M 2XX F Months Days Hours Min. (Month 27/1957 Director Yrs Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Baltimore Dundalk 28a-f 1 ☐ Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 2073 Larkhall Road 23a 21222 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: white Completed 3 Divorced Specify er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 7 is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John McNicholas Mullers 19a. Informant's Name/Relationship (Type, Print)
Stephen P. Feuerhardt/Husband 19b. Majling Address (Street and Number or Bural Road Dundalk MD 21222 f item 27 i r other tra 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it
any injury or o Ardent Crematory 4/9.2010 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens, Funeral Home 1501 E. Fort Avenue, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on eacl, line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine burial-trar Due to (or as a consequence of) physician s the burlar Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No 24a. Was an autopsy Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 🗌 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year O Physician/ Month 3 RGUSON THIA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Anne Arundel Tate House Linthicum 8. Date of Birth (Month, Day, Yea Sept 4, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 M 2 F Hours Ohio Director 220-60-8306 Yrs T952 57 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD <u> Anne Arundel</u> Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 USA 13 3rd Avenue SW 12. Was Decedent Ever in U.S. Armed Forces?
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Doris Jean Sheppard ၉ Charles Russell Clair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1308 Cape St. Clair Road Annapolis, MD 21409 Charles Clair Jr/brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service State and Andresom Facility oard 655 W. Baltimore Street MD Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day should be detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy performed or Attending Physician: The 1 Yes this certificate completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 2-No ္မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director. After work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the within 2 To the F only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

Registrar

State

31. Date filed (Month, Day, Year)

APR 08

Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

DEFENSELTECHWAY

TNNAPOUS MAZIYUI

Name and address of person who completed cause of death (Item 23a) (Type, Print) KENTA W

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Rita Catherine Glenn April 4:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Joseph's Nursing Home Baltimore Catonsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral nth, Day Months 218-18-4413 92 **Director** 1918 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location ral", or items 23a or 28a-f shorex examiner must be notified at 10d. Inside City Limits Director Maryland Carroll Sykesville 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5838 Westchester Hills Court 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ian "natural", o Medical Exam 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Sales Person Retail other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William R. Eberling Mary Winifred Mulcahy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a Mary Frances Johnson, Daughter 5838 Westchester Hills Court, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State 04/10/2010 Baltimore, Maryland New Cathedral Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility MacNabb Funeral Home, P.A. -Alice Iser 301 Frederick Road Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ea Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year the Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No this certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After that in by the funeral 27. Man er of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) 2010 5 completed cause of death (Item 23a) (Type, Print) 405 M.D. 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar		(Certificate of	Death			Reg. N	2010)	10767
	Physicia		Decedent's Name (First, Middle, Las		Gillooni	•			2. Date of Dea Month	D	ay Yea	r	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give	(evin Rand street and number)	Gillespi	4b. City, Town,	or Location	of Death	<i></i>		c. County of De	eath	7:56 A ^M
	LAGIIIII	CI		stream Dr. #2		is. oig, iom,		ımbia		Ι.		How	ard
Ī	Funeral		Social Security Number 6. Se		n yrs. last birthd	Months Days		r 24 Hrs. Min.	8. Date of Birt (Month, Da	th v. Ye <i>ar</i>)		Birthpla Country	ace (State or Foreign
	Director		213-50-9075 Usual Residence of Decedent	60 Apr 26, 1949								lowa	
	ind show at	o	10a. State 10b. County	1	0c. City, Town o	r Location						10	d. Inside City Limits
	faryla 3a-f s tified	ect	MD Ho	ward			Colu	umbia					1 🗆 Yes 2 🔊 No
	the N or 28	Ωį	10e. Street and Number			10f. Zip Code				10g. C	Citizen of What	Countr	y?
	s 23a ust b	Funeral Director	10107 Windstream Dr.	#2			21	044			U	.S.A	•
	death item ner m		11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	 Was Decedent of I If Yes, specify Cub 	Hispanic Or an, Mexica	rigin? (Spe an, Puerto i	cify Yes or No- Rican, etc.)		14. Race - Ar		
36	after al", or xami	d by	1 Never Married 2 Married 3 Nidowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give		1 🗆 Yes 2 N	o Specify	y:	Speci			ack, White, etc.	
ğ	hours natura ical E	lete	15. Decedent's Ed		16a. D	ecedent's Usual Occu	pation			16b.	Kind of Busines	ss Indu	istry
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2	ygien ygien her th	Travel Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)									1	rave	el
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Š	should b and Mer 7 is mark raumatic	-	19a. Informant's Name/Relationship (Ty	Shoemake or Town, State,		1-1							
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ē,	and Hea em the		20a. Method of Disposition		20b. Place of D	0107 Windstre			Date		Location - City	or Tow	n, State
Ë	Page 1 ment of ant: If it ury or o		1 A Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		,	crematory or other pla of Heaven Ceme	· ·	Apr	09, 2010		Silver Sp	ring	, Maryland
Baltimore,	permit, Page Department of Important: If any Injury or once.	21. Signature of Funeral Servic Lice see											-
	20 5 6 6	23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
		shock, or heart failure. List only one cause on each line. Immediate Cause (Final											
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	ertific ding p	/W	IF FEMALE:	23c. If yes, outcome of	pregnancy						22d Data of	dolivon	
Rox	death cer ne attendi ed for use	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at ti	□ Fetal death	3 Ectopic pregnar 5 Other (specify)	ncy			- 1	23d. Date of o Month		y Day Year
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Z Z	nding ath. Afte fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,)	<i>(ear)</i> inju	iry wo	rḱ? ☐ Yes 2 [_			.,,		
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For			State of	of Ma	ryland				Health and	d Mer	ntal Hy	/gien	e	0	107	0
		State Registrar						Cer	tifica	te of L	Death			Reg. N	0 U	U	101	68
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Medic	al	Mar) 4a. Facility Name (if			inner		l						3	20		210	9:15	/) M
Examin	er	3725 Wh		•		,			4b. Cit		r Location of Dea dle Rive			4	c. County o			
Funeral Director		5. Social Security No. 219-32-		6. Sex	M 2 😿 F	7. Age	(In yrs. las	st birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 Hi Hours Mil		Date of Bir (Month, Da 11 29	rth ay, Year	36	g. Birth Vir	place (State or ntry.) ginia	Foreign
nd thow at	٦	Usual Residence of 10a. State	Decedent 10b. County				10c. City,	Town or Lo	or Location								10d. Inside City	/ Limits
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 ☐ Burial 2 4 🎇 Donation	☐ Cremation		emoval from	State		ace of Dispo metery, cren			ce)	Date		20c. l	_ocation - (City or T	own, State	
permit. Departi Import any inj		21. Signature of For	onald	icensee W	ade,	Yre	ctor				ss of Facility Omy Boat MD 212		55 W	Ва	1timo	re S	Street	
		23a. Part 1. Enter the shock, or hear	the disease, or	complic	ations that	caused t	the death.	Do not ente	er the mo	de of dyin	g, such as cardia	ac or res	piratory a	rrest,			Approximate Interval Betw	oon
Physician/		Immediate Cause (disease or conditio	Final	y 0.10			age	Cardi	omy	10 part	ny						Onset and De	
Medical Examiner		resulting in death)		ſ.	Due to	(or as a	conseque	ence of):										
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medic	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1										rery Day Ye	ear					
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Vith Vith Cort		29b. Signature and	title of certifier y wall	MID						Dono					ate signed (Day, Year)	
•		30. Name and addre	ess of person v	vho con	pleted caus	se of dea	ath (Item 2	3a) (Type, P			7465							
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azel J. Gamble		State of Maryland / Department of Health and Mental Hyg	giene	2010	10100
		1- For State Certificate of Death	Reg.		
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⁴≏dical Exami	ner		March 25, 20	4c. County of Death	07201113
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 324 S. Monroe Street Baltimore		4c. County of Death	
			8 Date of Birth/	MM/DD/YYYY 9. Birtl	nplace (State or unk
Funeral Director		Months Days Hours Min	Apr 17,	Foreign	
Director	Ļ	1 NV.	АРГ 17,	1511 000	, indy)
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
≹ ,₁		MD Baltimore			1 X Yes 2 No
Aaryland 28a-f show 1 at once.	흱	10e, Street and Number 10f. Zip Code	10g.	. Citizen of What Coun	try?
ith the Maryland 23a or 28a-f sho notified at once.	Director	324 S. Monroe Street 21223		USA	
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f shent, the Medical Examiner must be notified at once			cify Yes or No-	14. Race - Americ	can Indian, Black,
ath w items	Funeral	1 Never Married 2 Married Armed Forces? unk If Yes, specify Cuban, Mexican, Puerto Ri		White, etc.	
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Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		21. Sign ture of Euneral Price Licensee Point State Anatomy Board		Baltimore	Street
	\dashv	23a. Park I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or n	espiratory arrest	t, shock, or heart	Approximate Interval
Physician		failure List only one cause on each line.		7	Between Onset and Death
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Division of Vital Records, tal or attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be			and. Describe no	w injury occurred	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and death occurred at the time, date and death occurred at the time, date and date and date and date are the time, date and date are the time, date and date are the time, date and date are the time, dat	the time, date ar	nd place, and due to th	e cause(s)
To the within To the Comple	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
	=0	O.C.M.E.		March 26, 2010	
		N-WU-IM			
		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
	tate	16 31. Date filed (Month, Day, Year) 32 Registrar's Signature			
Regis					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death t. Decedent's Name *(First, Middle, Last)* **Frank Nicholas** 2. Date of Death Hupfl, Jr. Physician/ 3/30/2010 3:30am [™] Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death

Linthicum 4c. County of Death
Anne Arundel Hospice of the Chesapeake, Tate Hous Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 218-36-8535 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F 69 Months Hours Min (Month 1994/19940 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director 10d. Inside City Limits MD Anne Arunde Brooklyn Park 1 Yes 2 KNo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 421 Bon Air Road 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 🏝 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white d Mental Hygiene. marked other than "natural", 3 Divorced Specify Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Mechanic Glass Manufacturing Be 17. Father's Name (First, Middle, Last)
Frank N. Hupfl 18. Mother's Name (First, Middle, Maiden Surname)

Mary Wagner ဂ္ permit. Page 1 and 2 shoul Department of Health and I Important: If item 27 is ma RODIN Ann Hupil / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 Bon Air Road, Brooklyn Park MD 21225 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Glen Haven Cemetery 4/2/2010 Glen Burnie, Maryland injury (4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner a ceu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an After this certificate has 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred XX Natural injury 5 Pending Investigation Accident within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number 2783 March 31, 2010

Registrar

DHMH 17 Rev 7/2009

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State

203 Mospital Drive Glen Burgare MD 20061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G0856/7

31. Date filed (Month, Day, Year) APR 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\mathrm{Aprih}_{\mathbf{r}}$ 2018 Roberta L. Himes 3:15 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 116 Forest Drive Catonsville Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) AUR 9, 1936 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Min. Pennsylvania Director 224-44-1690 73 Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Catonsville Baltimore Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 116 Forest Drive 21228 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: White Specify: "natural". 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse Hospice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert McCleary Estelle Loeffler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6601 Altamount Avenue Catonsville, Maryland 21228 Jean Bridle, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🕅 Cremation 3 🗆 Removal from State Metro Crematory Inc. 04/07/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore 21. Signature of Funeral Service Licensee lane and Address of Facility CNABO Funeral Home, P.A.)I Frederick Road Catonsville, Thomas Gregor Maryland 21228 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final JULTIPLE Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be execute signed by the attending physician and defached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Live Green in the past 12 months? Month Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown MELLITUS Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy performed' 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 2 No os Ace 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of 28d. Describe how injury occurred or Attending Natural 5 \square Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated d title of certifier 29b. Signature State Registrar

DHMH 17 Rev 7/2009

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O.C.M.E. April 6, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar DHMH 17 Rev 1/2001 ORIGINAL OCME	o the Hospi ithin 24 hou o the Funer ompletely fi	9	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at Medical Examiner: On the basis of examination and/or investigation, in	t the time, date and place, and o	due to the cause(s	s) and manner as state	ed.	
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Box 68760, P.0. Records, Division or Vital

Medical Examiner certificate be executed and burial-tran attending physician for use as the buria ed by the detached signed by certificate After this in by the funeral Attending •• Hospital or At.
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•• Director: A*

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permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important: If Item 27 Is marked other any Injury or other traumatic event, tt

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Baltimore,

Director

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Certification:

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25. Was case referred to med	ical	26. Place of Death (Check only one)											
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	cal Examiner: Or						and due to the cause(s) red at the time, date and						

29c. License number

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7300 Van Dusen

Hospita

29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas H. Burguieres, MD Laurel Reg 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

DHMH 17 Rev 1/2001

Laurel Regional

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 201<u>0</u> Physician/ March 29, 1:15 AM M <u>Loretta K. Harlan</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Timonium Stella Maris Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗓 F Months Days Hours Min ar 19, Year) Mary Land Director Mar 102 216-01**-**4961 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2X No MD **Baltimore** Timonium 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21093 USA 2300 Dulaney Valley Road 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🕅 No Specify: white Specify 3 X Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within housewife own home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis Patrick Kelly Mary Elizabeth Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau Charles W. Harlan/step son 5917 Meadowood Road Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) cemetery, crematory or other place. State Anatomy Board 655 W. Baltimore Street MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Meumoni Ph/sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for a 4 Pregnant at time of death 9 Unknown Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy death? After this certificate 1 Yes 2 No Yes Division of Vital To the Hospital or Attending Physician; 25. Was case referred to medical completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination arrayor investigation, it may open the state of the cause (s) and manner as stated.

2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie L157624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

LORETTA

2300 DULANEY VALLEY ROAD, TIMONIUM, MD 21093

CRNP

JENNIFER HAUF,

PR 08

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 23^{Day} 2010 March 1:44 Рм Vicky Dru Hartin 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 1000 Franklin Ave; #208 Essex 8. Date of Birth (Month, Day, May 18, If Under 24 Hrs. Birthplace (State or Foreign
Country) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 1951 Pennsylvania Months Days Hours Min. 1 ☐ M 2 💢 F 217-56-9344 58 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 ☑ No Baltimore Essex MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21221 1000 Franklin Avenue #208 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 A Married Specify: white 1 □Yes 2X No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Thermo Sash Windows office manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Marlene Thomas George Curtis Housel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1000 Franklin Avenue #208 Essex, MD Michael Hartin/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Tup tured cerebral aneurysm

Due to (or as a consequence of): Approximate Interval Between Onset and Death 14 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 1 X Natural 2 Accident 5 Pending investigation

Physician /Medical Examiner Examine

Physician

/Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examines must be really of

Saltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

The law requires that the death certificate be executed the burial-trans the attending physician hed for use as the buria signed by t be detach icate has been sig ; page 2 should b To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, completely

Physician/Medical

þ

Completed

Be

Certification: To

Medical

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

MD.

D56531

March 25, 2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry LI 10780 Hickory Ridge Rd. Columbia, MD 21044

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year HEWYLEN 01:30AM 2 B 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Frankford Nursing Home Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 110k 8. Date of Birth (Month, Day, Year) Months Days Hours Min. unk 1 □ M 2 😾 F Yrs. 214-56-9304 60 Dec 2, 1949 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√EYes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5009 Frankford Avenue 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: black 1 ☐ Yes 2 🛛 No Specify 3 ☐ Widowed 4 ☐ Divorced unk unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 Frankford Avenue Baltimore, MD Frankford Nursing Home 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) in state 21. Signature of the ra Service on a Ld State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Call Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consecue resulting in death) Last Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and P.O. Box 68760, attending physician the as use for the detached signed by the detachε Division of Vital Records, this certificate within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral.

Physician

/Medical

Examiner

Examiner Physician/Medical ð Completed Be ပ Certification:

Physician

/Medical

Director

Funeral

þ

Completed

Be ဥ

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, ith Mackal Examinating is at the rediffed at once.

Baltimore, Maryland 21215-0036

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								24a. Was an autopsy performed? death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No				
25. Was case refer	red to medical	26. Place f Death (Check only one)										
examiner? 1 ☐ Yes 2 ☑	No	Hospital	1 ☐ Inpatient 2 ☐] ER/Outpatient	3 🔲	Home 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manny of Deat 1 atural 2 Accident	h 5 Pending investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Nork? Injury M 28c. Injury at Work? 1 □ Yes 2 □ No										
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of Injury - At h building, etc. <i>(Speci</i>	ome, farm, stree	et, facto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only	1 Certifying Ph 2 Medical Exan	niner: O	To the best of my known the basis of examina	owledge, death ation and/or inve	occurre estigati	ed at the time, on, in my opinion	date and place on, death occ	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)				

29c. License numbe

29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year

APR 08 2010

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

April Apri	1777
## Private Processor Part	e of Death
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Director Dir	
December The Provided December Decem	te or Foreign
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FFMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 23d. Date of delivery Month Day Day Day Day Day Day Day Day Day Day Day Day D	
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26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 28. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28c. Injury at work?	
27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28c. Injury at work?	
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4 ☐ Homicide determined determined building, etc. (Specify) 4 ☐ Homicide determined building, etc. (Specify)	,
29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	manner stated.
only one) 3 \square Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
RES 001 MARCH 28 201	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEAN HEFFERNAN, MD 4940 FASTERN AVENUE BALTIMORE MD 21224	
State Registrar 31. Date filed (Month, Day, Year) APR U S 2010 APR U S 2010 APR U S 2010	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month A-PR Physician/ 11:10A M Jon C. Herring 2010 02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT MEMORIAL HOSPITAL EASTON 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday **Funeral** 1 💢 M 2 🗆 F Months Hours Mar 21, Year 958 TEXTA'S Director 52 217-74-5130 Usual Residence of Decedent Show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No DEnton MD Caroline 10f, Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Completed by Funeral 21629 USA 12786 Holly Road 12. Was Decedent Ever in U.S. Armed Forces?

1 🛣 Yes 2 🗆 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. white **'**75-83 Specify: 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) police officer law enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Valeria Carver Jesse Clyde Herring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jon Herring Jr/son 412 CEdar Lane Greensboro, MD 21639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature Ronald Service Licenses Wade State and Address of Facility oard 655 W. Baltimore Street Baltimore. MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician. SEPSIS disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) DAYS SEVERE METABOLIC ACIDOS 15 Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit DAYS ACUTE RENAL FAILURE and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician HEPATIC Physician/Medical FAILURE HOURS for use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Yes 2 No by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by ge , Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an nas I autopsy performed death? certificate 1 ☐ Yes 2 ☐ No Yes 2 No Physician: filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 2 🗌 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Suicide Investigation within 24 hours after deatl

To the Funeral Director,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) to Rawrelow MD D66441 03 2010

State Registrar

NOL

HERRING

2195

32. Registrar's Si

WASHINGTON STREET

21601

MD

EASTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMESH

31. Date filed (Month, Day, Year) APR 08 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Howand Ye ar Anna /Medical MARCH 30. <u>11:</u>45a[™] 2010 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FRANKFORD NURSING HOME BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F Months Days Hours Min Director 220-30-8831 97 5-4-1912 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantines must be notified at 10d. Inside City Limits MD. Director N/A BALTIMORE 1 X Yes 2 □ No the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1227 N. BENTALOU ST. Completed by Funeral 21216 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 □ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and 2 should be filed within leath and Mental Hygiene. m 27 is marked other than College (1-4or 5+) -6-**-**0. HOUSEKEEPING DOMESTIC 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) TONY HOWARD ပ NETTIE AMBUSH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is ANTHONY WILLIAMS (GRANDSON) 516 CATHEDRAL ST. BALTIMORE, MARYLAND 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important; If its any injury or o 1 Burial 2 Stremation 3 Removal from State 4 Donation ☐Other (Specify) METRO CREMATORY 4-9-2010 BALTIMORE, MARYLAND 21. Signature of D. HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. iner Service Mce MAHTANO (902) 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. 23a, Part 1 Approximate Interval Between Onset and Death show or heart failu Immediate Cause (Final disease recondition resulting in death) **Physician** metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) by the a ☐Yes 2XNo 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page autopsy certificate perform 1 □ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X**No ٩ 1 ☐ Yes this 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. within 24 hours after death

To the Funeral Director:

completely filled in by the f ☐ Accident 1 □Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical the) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 140 0 43380 4.1.10

DHMH 17 Rev 1/2001

State Registrar

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1714

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend #1 Per Phy G902 4/08 2010 JH.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9:12AM 2010 brot /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore HR - 501Catonsville 719 Maiden Choice Lane, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6 Sex **Funeral** Months Min Days Hours 1 □ M 2 ▼ F 161-40-8668 98 July 5, 1911 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County if than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 719 Maiden Choice Lane, HR-501 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify þ White 3 ¥ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **5+** permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Insulonce. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brindley Laura Frances Barney Robert 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Georgetown, PA 15043 H. Mark Jones, son 1981 Route 168 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 04/03/10 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severe **Physician** Aortic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy 5 Other (specify) P.O. the 9 ☐ Unknown 9 Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7-11 Deneen Bowlin Marden 31. Date filed (Month, Day, Year) 2. Registrar's Sign State APR 08 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ludre 3:55A M 10 Medical 4a. Facility Name (if not institution, givestreet and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 DM 2 X F Months Sept. 5. 1913 96 Maryland 215-09-8508 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 X No Maryland Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Maiden Choice Lane United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 e filed within... antal Hygiene... **her than "natural", o Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Adolph Allan Lillian M. Hulurstumpp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonita L. Bannar/ P.O.A. 617 Tamiami Trail North Unit 35, Venice, Florida 34285 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprilate 8. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2010 Baltimore, Maryland 21. Signature of Funeral Service License Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition meumoni Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iii)jury that initiated events Due to (or as a consequence of) Examin Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The law requires End-Stage icate has been siç , page 2 should b Demen 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 NO မ 1 Inpatient 2 ER/Outpatient 3 DOA After this (28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Decritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 E 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Bowlin 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2010 11:22 PM Zella Mae Jenkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Savage La Casa De Rosa If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, ug. 29 1 □ M 2**X**XF Months Days Hours Min Maryland 212-18-4560 Director 89 Aug. 1920 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Carroll Finksburg MD 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 21048 USA 3409 Edolin Farms Court items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ö þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. If Yes, Give "natural", White 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) US Government Postmaster 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roxy Nell Mathews Carl Bailey Redmond permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic t 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold L. Shaffer / Son 3409 Edolin Farms Court, Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Meadowridge Mem. Pk 4/9/2010 Elkridge, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. Laurel, 20707 M01103 313 Talbott Avenue, 23a. Part 1 Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Dause (Final disease or conditions) Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and -trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached g Unknown g 🗌 Unknown ficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending death. 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

State Registrar 29b. Signatu

filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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0030 bours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	Usual Residence of Decedent 10a. State MD Prince 10e. Street and Number 4742 68th Place 11. Marital Status 1 M Never Married 3 Widowed 4 Divorced	George's H 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give	yattsv	10f. Zip-Code 20 Vas Decedent of Hir Yes, specify Cuba	ispanic Origin? n, Mexican, Pu	? (Specify Yes or No Lerto Rican, etc.)	US.	A e - American Indian, ck, White, etc. h 1 a.c.k			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 9:10 Evelyn Kipp Jarrett 20TO Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗶 F Days Hours 37 CourMaryland 219-34-0064 September 14,19 **Director** 72 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Owings Mills Maryland 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 411 Garrison Forest Rd. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates white Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 alth and Mental Hygiene.
127 is marked other than "r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) education/school bookstore manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hiram Caleb Kipp Evelyn Pryor permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin B. Jarrett Jr./husband 21117 411 Garrison Forest Rd. Owings Mills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Thomas Church Cem. Apr. 9,2010 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Maryland 21. Signature of Funeral Service Licensee LChell-Wiedefeld Funeral Home, Inc. OO York Rd. Baltimore, MD 21212 6500 York Rd. 23a. Pdf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Ademo corcinomo Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No page (1 Yes 2 No Yes 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Natural 5 Pending n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar

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CHARLES

32. Registrar's Signature

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Year)

31. Date filed (Month, Day, APR 0 8

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend #17 per Fh & #30 per DVR G902 478/10 TII State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 7:50 PM Konway 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD MORNINGSIDE HOUSE ELLICOTT CITY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Months Min 47671924° 85 MD Director 219-18-4539 Usual Residence of Deceder "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 🐰 No HOWARD ELLICOTT CITY MD 10e. Street and Number 10g. Citizen of What Country? Funeral 21042 USA 4060 FRAGILE SAIL WAY 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) **TEACHER** EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ PHILLIP Philip **JACOBS** MOLLIE LEVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 4060 FRAGILE SAIL WAY, ELLICOTT CITY, MD MARSHALL MACKS/NEPHEW 20a. Method of Disposition 20c. Location - City or Town, State 20b. PIRFOT PISPOS GO AND ME ADATH Date 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MD ISRAEL CEMETERY 4/7/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility INC. 21208 Seett 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Atherosclerosis disease or condition 100. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident (Month, Day, Year) injury 5 Pending nours after death. 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my entired. Medical 29a. Certifier completed The deficiency in y strain. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 058942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter Yang Chi, MD 8186 Lark Brown Rd. Suite 201 Elkridge, MD 21075
31. Date filed (Month, Day, Year) 32. Highstrar's Signatures Applications of the Company of the Compan 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

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Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month "JOAM 010 rginia APRU Medical 4a. Facility Name (if not institution, give County of Death **Examiner** Town, tons VII a . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Hours Director or 28a-f show a notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Jown or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No More 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates. 2 **N**o 21215-0036 1 ☐ Yes 2 M No Specify. Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnar ပ temus rooks an 19a. Informant's Name/Relationship (Type, Print). 19b. Mailing Address (Street and Number or Rural Route Number, State, Zip Code) Woodbrie 22192 (niece) 3426 Nanda 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-10-2010 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 23a. Part 1. Erter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PINA Immediate Cause (Final PNEUMONIA TION Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Cause (Disease or liniury and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant
9 Unknown Pregnant at time of death 5 Other (specify) 2 No the detached 9 Unknown P.O. within 24 hours after death.

To the Funeral Director; After this certificate has been signed by completed filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 Unknown 1 🔲 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? ALTERY DISEASE 24a. Was an autopsy 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Vital Be 26. Place of Death (Check only one) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ot 28a. Date of injury (Month, Day, Year) 27. Manner of Deal 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending Division 1 Tyes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the D0061765 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 WILKENS AVE #307 BACTIMODE MD 21229 QUAINDO MO 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 March 9:13 PM Larry Allen Luttrell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Devlin Manor Cumberland 5. Social Security Number If Under 1 Year If Under 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 XM 2 - F Months Days Hours Min. 01/14/1947 West Virginia **Director** 235-68-8814 63 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Cumberland MD Allegany 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 U.S.A. 515 Henderson Avenue filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Force Black, White, etc. δ 1 Never Married 2 Married Yes 2 K No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8 Heavy Equipment Operator Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) മ Elber Correl Luttrell Fritzman Dortha . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freda Luttrell / Wife Henderson Ave., Cumberland, MD 21502 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1
Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 04/08/2010 Hanover, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 752<u>2</u> Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac a respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on earn line. Immediate Cause (Final acenon Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): nding physician and use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g 🗌 Unknown 9 Unknown P.O. I Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has t autopsy 1 🗌 Yes Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature at 1)0033280

State Registrar 628

21502

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#7perFH.G902.4/9/2010.WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 02° 2010 ear Physician/ April 6:10 P. M н. Yun Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard 10799 Hickory Ridge Rd #114 Columbia If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 08-20-2 1 ★ M 2 □ F Hours 239-43-4244 83 Korea Director Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 Yes 2XX No MD Columbia () Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō er than "natural", or items 23a of the Medical Examiner must be Funeral 10799 Hickory Ridge Road, 114 21044 Korea Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No ð 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) VFW Facility Janitor unknown Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kum Bong Kim permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic ince. Yong Heui Lee traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, MD 21044 10799 Hickory Ridge Rd. 114, Hae Suk Lee - daughter-in-law Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem Prk. | 04-07-2010 | Elkridge, Maryland 4 Donation 5 Other (Specify) 21. Signaru 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Stomach Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examin physician and s the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2 **N**No 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ORI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAIT, more 7. Age (In yr last birthday) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 TF Months Hours Min Director MD cember 15,19 ys Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination to notified at YES 2 No Completed by Funeral Director m.D BAITIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21.5.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) HelpingNurses Elementary/Secondary (0-12) Ursing 5/191 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ex ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Fute Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and Important: If Item 27 is any Injury or other trauonce. MC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** an /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛣 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 41536

Registrar
DHMH 17 Rev 1/2001

State

Blvd, Rall-MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Virginia Celeste McAuliffe 3:58 P M Apr 3, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Howard Shangri La Assisted Living If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 M 2 XF Months Davs Hours Min. Country) Director 023-18-3525 85 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Tes 2 No MD Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18007 Brooke Farm Dr. 20832 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 🗆 Yes 2 No Specify 3 Widowed 4 □ Divorced Completed Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Chaplain hooon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia McAuliffe Daughter 5350 Ambrosia Dr. Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Apr 05, 2010 Glen Burnie, MD Atlantic Crematory, LLC 21. Signature of Funeral 22. Name and Address of Facility ice Lie ne Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as | consequence of) Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) 1 Yes 2 completed filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 잍 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spe 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in magnitude. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 - Gertifying Nurse Practioner T. the best of my knowledge. Seath oncurred at the time, date and blace, and due to the nause(s) and incomer as stated 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Dey

APR 08 2010

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 29 , Day 2010 Year JOHN JOSEPH MORTON II 8:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD AIR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV. 22 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1 5M 2 F Hours 90 Director 1919 New Hampshire 017-14-8113 Usual Residence of Deceden and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 1 X Yes 2 ☐ No York Wells Maine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Fern Street 04090 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George (nmn) Morton Hazel (nmn) Knowlton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. 12 Fern Street, Wells, ME 04090 Pauline Morton / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗆 Cremation 3 🖳 Removal from State 4 Donation 5 Other (Specify) Unk UNK UNK McConas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Inter the disease, or complication, the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death LOSALDI Physician/ disease or condition resulting in death) 4 hours Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury physician and the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death igned by the attendin be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth 2 Live Fetal 3-4
4 Pregnant at time of death
9 Unknown in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 300 To Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cartifying Nurse Practioners To the best of my knowledge, death occurs d at the time, date and place, and due to the 29b. Signature and title of certifi 00056296 641 D. 500 upper Chesapeake Dr. Bel Ar, mp 21014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jasa Birnbaum, m 31. Date filed (Month, Day, Year) APR 0 8 2010

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month APR 1 Year 2010 **Physician** JILLIAN ANGEL MCCORMACK 11:29 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 6. Sex If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 23 1 ☐ M 2 🔀 F APR 1 Director MD None Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, In. It official Examiner in 1st be notified at 1 ☐Yes 2X No Director Anne Arundel Odenton MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21113 United States 540 Bruce Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No by Specify. If Ves Give Specify. 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 h (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant 0 Infant and Mental Hygie is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fith and Mental I Jennie June Glover 2 Jeffrey Alan McCormack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) ages 1 and 2 nt of Health a Jeffrey A. McCormack / Father 540 Bruce Avenue Odenton, Maryland 21113 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I injury or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department Important: If any injury o 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory | 04-08-2010 Odenton, Maryland 21. Signature of Juneral Service Lic 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. <u>1411 Annapolis Road Odenton, Maryland 21113</u> Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between immediate Cause (Final Physician PREMATURITY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. attending physiciar certificate be Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the ☐Yes 2 No o. 9 I Unknown signed by ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗆 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred al or Attending Patter death.

I Director: After din by the funera Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD048338L (PA)

State Registrar

DHMH 17 Rev 1/2001

MAUREEN L. TATE LTC MC USA 31. Date filed (Month, Day, Year)

30. Name and abdress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NATIONAL NAVAL MEDICAL CENTER

10-02583		Please Type or Print in Black Indelible Inl			gible.	
Anthony Harrison		cNeill State of Maryland / Department of I		al Hygiene	2010	10791
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Jealii	2. Date of Dea	leg. No. 💪 🖰 📗 U	3. Time of Death
Medical Examin		Anthony Harrison Mcne	: //	Month April 2, 20	Day Year	1015 hrs
<i>'</i>		4a. Facility Name (if not institution, give street and number) 4b	. City, Town, or Location of		4c. County of Death	1
			Baltimore			
Funeral Director			Months Days Hours	Min .	rth(MM/DD/YYYY) 9. Bir Foreig	in
Director		216-94-3666 1 MM 2 F 44 Yrs.		4-6	-1965 °°	untry) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1			10d. Inside City Limits
	١	MD Baltimore Guyinn	Oak			1 Yes 2 No
faryla 28a-f	Director	10e. Street and Number	10f. Zip Code	1	l0g. Citizen of What Cou	ntry?
3a or		6828 Westridge Road	21207		USF.	7
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral		Decedent of Hispanic Origin , specify Cuban, Mexican, I		 14. Race - Ameri White, etc. 	ican Indian, Black,
		1 ✓ Yes 2 No	es 2 No specify:		Specify: B	lack
215-0036 be filed within 72 hours after that "Hygiene. rked other than "natural", ent, the Medical Examiner	<u>۾</u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Usual Occupation (Give ki		16b. Kind of Business/I	Industry
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Baltime permit. Pag Department Important:	Ì		ne and Address of Facility	auchy C.	Greene Fune	
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	28 Liberty.	Rat Karda	11stown, M	Approximate Interval
Physician di al		failure. List only one cause on each line.		diacor respiratory arr	est, shock, or realt	Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death) a. Narcotic (heroin) in Due to (or as a consequence of):	toxication			Dogui
		Sequentially list conditions, b				
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Records, P.O. Box 68760, The law requires that the death certificate be ex cate has been signed by the attending physician page 2 should be detached for use as the burial		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth	death 3 Ectopic p		23d. Date of delivery Month) Day Year
th cert	흲	past 12 months? 4 Pregnant at time of death 5 Other	(Specify)			
Box he death c	آڇ	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the unc	lastrias as usa siras is Dod	I 230 Did to	obacco use contribute to	the cause of death?
P.O.	<u>۾</u>	Cocaine use	lerrying cause given in Part		s 2 No 3 Prob	
dS, lequires	Completed	Cocarne use		24a. Was	an 24b. Were au	topsy findings available
COF law re has by	틹				rmed? death?	completion of cause of
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of Vital Records, ng Physician: The law requin Mer this certificate has been si meral director, page 2 should I	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	Othor:		Residence 6 🗸 Other	: Scene
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Division tal or Attendi rs after death. al Director: /	<u>≅</u>	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc.	28f. Location (S	Street and Number or Ru State) 2332 Anok Ore, MD	ral Route Number, City a Ave
Divisior Hospital or Attend 24 hours after death Funeral Director: etely filled in by the 1	පි	4 Homicide determined (Specify) house 29a. Certifier 4 Continue Physician. To the best of my provided a death occurred				
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	<u>ह</u>	one) 1 Certifying Physician: To the best of my knowledge, death occurred (Check only) Nedical Examiner: On the basis of examination and/or investigation				
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	
		Mayor De Wall	O.C.M.E.		April 3, 2010	
	ŀ	30. Name and address of person who completed cause of death (Item 23a)			<u> </u>	
			n Street, Baltimore,	MD 21201		
Sta		31. Date filed (Month, Day, Year) APR 08 2010 32. Registrar's Signature April 10 2010	4			
Registr	ŒШ	MIN V CUIU COMMENT				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Death)av Year	3. Time of Death
Medical Exami	ner	Clement Marks		41 0'1 T		March 22, 2	010	0529 hrs
		Facility Name (if not institution, give street and number) 12500 Willowbrook Road		4b. City, Town, or L Cumberland	ocation of Death		4c. County of Deat Allegany	
Funeral Director		1 M 2 F	yrs. last birthday) 53 _{Yrs}	If Under 1 Year Months Days s.	If Under 24Hrs. Hours Min.	8. Date of Birth (June 12	(MM/DD/YYYY) ^g . Bi	rthplace (State or Foreign ountry) UNK
any		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Local	tion				10d. Inside City Limits
<u> </u>	ō	MD Allegany	Cumberla	ınd				1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Cou	intry?
vith the s 23a o		14100 McMullen Hgwy SW 11. Mantal Status unk 12. Was Decedent Ever	in U.S. 13. Wa	21 as Decedent of Hisp	502 anic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ame	rican Indian, Black,
death v rr item	Funeral	1 Never Married 2 Married Armed Forces?		es, specify Cuban,			White, etc.	
rs after ural", c	ē	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete)	1	Yes 2 No		ork done 1170 kg 1	Specify: b1 6b. Kind of Business	ack Industry unk
72 hour n "nate	eted	Elementary/Secondary (0-12) College (1-4 or 5+)		nost of working life. I			ob. rand of Edsiness.	industry diffe
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examiner	Completed	unk unk		15-174	N. A. de Maria	/Circle Middle Mari	dan ()	amle
21215-0036 Mold be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she e event, the Medical Examiner must be notified at once	BeC	17. Father's Name (First, Middle, Last)		unk 18	s.motners Name	(First, Middle, Mai	iden Surname)	unk
7. 2 9 g s		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or R	tural Route Numbe	er, City or Town, State	e, Zip Code)
nd 2		O.C.M.E. 20a. Method of Disposition	113 20b. Place of Dispos	Penn Sta			MD 21201 20c. Location - City of	Town, State
Baltimore, MD 2 permit. Pages I and 2 shoul Oppartment of Health and N Important: If item 27 is n injury or other traumatic		1 Burial 2 Cremation 3 Removal from State	crematory or ot	her place)			·	
Baltimo permit. Page Department c Important:		4 Donation 5 Nother Specify: in state 21. Signature of Fundal Service Licensee nail of Nother Directions	tor 22.1	Name and Address of	of Facility	1 655 W	Baltimore	Street
		23a. Pailt I. Enter the disease, or complications that caused the disease.	I R=	1timore	MD 2120	11		Approximate Interval
Physician /Medical		failure. List only one cause on each line.		ne mode or dying, si	JCT as Cal Glac O	respiratory arrest	, SHOCK, OF HEAR	Between Onset and Death
Examiner		mmediate Cause (Final disease or condition resulting in death) a. Bleeding Duodenal Due to (or as a consequence)						1
	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequer	nce of):					
	Examiner	(Disease or injury that initiated events resulting in death) Last	nce off:					
cuted ind transit	Ĕ	events resulting in death) Last Due to (or as a consequer d.						
50, te be executed sysician and burial - transit	ledical	UNPENDED AMENDED						
876(tificate ng phy as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth		etal death 3	Ectopic pregna		23d. Date of deliver Month	y Day Year
OX 6876 eath certificate attending phy for use as the I	Physician/N	past 12 months? 1 Yes 2 No 9 Unknown g Unknown	of dooth	ther (Specify)		3.3	i.	
D. B t the d by the		Part II. Other significant conditions contributing to death but	not resulting in the u	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
b, P.(d by					1 Yes	2 ✓ No 3 Pro	bably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should!	Completed			· -		24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Rec The Is ficate h	Som				15 11 (8)	1 ✓ Yes 2		es 2 No
Vital F ysician: ' his certifi director, I	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 V ER/Outpatient		f Death (Check of ther: 4 Nursing		sidence 6 Othe	r:
ion of Vital tending Physician: eath. or: After this certif the funeral director,		27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of I	Injury 28c. Injury	at Work?	28d. Describe hov		
Sion Attend death. ector: by the f	catio	Pending Accident Investigation 2	At home form stre		s 2 No	20f Location (Stre	oot and Number or D	ural Route Number, City
Division pital or Atten our after death eral Director:	Certification	3 Suicide 6 Could not be determined (Specify)	Actionie, iaini, stre	et, ractory, office but	iding, etc.	or Town, State		oral Note Namber, Oity
Hos 24 h Fun rtely	I	29a. Certifier 1 Certifying Physician: To the best of my kno						
To the within To the comple	Medica	29b. Signature and title of certifier	ion and/or investiga	29c. License			9d. Date signed (Mo	
		(colorledes)		O.C.M			March 23, 2010	,
		30. Name and address of person who completed cause of death						
		Laron Locke MD. Assistant Medical Examin 31. Date filed (Month Dair Veer) 32. Registrar's Signary		Street, Baltime	ore, MD 2120)1	_	
Si Regis	ate trar	APR 08 2010 Seven	gnature	2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ MAGA Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 500 S. Marlyn Avenue Essex Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours DEC 10, Yan 55 1 X M 2 □ F 54 Iran **Director** 057-62-4349 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔯 No Baltimore Essex MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 500 S. Marlyn Avenue #2B USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married after 1 ☐ Yes 2 X No Specify. white Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) security guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fourouz Esfandiary Mirsamad Moghimi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Burl Court Parkville, MD 21234 8 Burl Court Parkville, MD Ken Moghimi/brother 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \bowtie Other (Specify) in State Signature of Lineral Service Lonald 28 Name and Address of Brailit Board 655 W. Baltimore Street Baltimore. MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure. List only one cause on each line Interval Between shock Immediate Cause (Final disease or con Onset and Death Physician/ Medical resulting in death) Due to (or as a consequenc Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events or as a consequence of resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death g Unknown P.O. signed k Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2500 Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗆 No this certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify, After this funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aff completed filled in by the ful 1 🗌 Yes 2 🗆 No M Accident Investigation Suicide 6 Could not be ☐ Suiciac ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature el title of certif 29d. Datersigned (Month ess of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

31. Date filed (Month, Day

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ı	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 9:30 MM					
	/Media		Denn LS Lee Mo(e) 4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location ol Death	05 2010 4:30 M					
	Examir	lei	Easton Memorial Hospit	ral easton	Talbot					
	Funeral		5. Social Security Number 6. Sex 7. Age (iii yis. las	st birthday) Trunder 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day,)						
	Director		infant Usual Residence of Decedent	Yrs. 4 10 4 5 1	10 MD					
	yland			Town or Location	10d. Inside City Limits					
	Ba-f el	ctor	MD Dorchester	Hurlock	1 ☐ Yes 2√∑ No					
	with th	Dire	10e. Street and Number		g. Citizen of What Country?					
	ns 234	Funeral Director	6533 Grave1 Branch Road 11. Marital Status 12. Was Decedent Ever in U.S.	21643	USA 14. Race - American Indian,					
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent; if Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Enantinal must be notified at ances.	b	Armed Forces? 1 XNever Married 2 Married 1 Yes 2 XNo 1 Widowed 4 Divorced Year or Dates:	 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 	Black, White, etc. Specify: White					
5	72 hc	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	6b. Kind of Business/Industry					
2121	within ene. than	ldmo	Elementary/Secondary (0-12) College (1-4or 5+) infant	infant	infant					
2	Hygi other ent, I	Be Completed	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (First, Middle, Ma	aiden Sumame)					
/lan	uld be Mental rrked	To B		Brittany Charro	n					
	and 2 should be filed within saith and Mental Hygiene. n 27 is marked other than "er traumatic event, the Meg		19a. Informant's Name/Relationship (Type, Print) Easton Memorial Hospital	19b. Mailing Address (Street and Number or Rural Route Number, C 219 S. Washington Street East						
altimore,	Pages 1 ment of He tent; if iten jury or oth		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) in state	ce of Disposition (Name of Date 20 Dat	Oc. Location - City or Town, State					
Balt	Depart Import any in		1. Signature of American Service disease de Director State and Address Mysacibo and 655 W. Baltimore Street Baltimore, MD 21201 3a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately 1. Approximat							
	Priysician /Medical Examiner	ner	shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the con	nce ol):	Inferval Between Onset and Death					
8760,	eath certificate be executed attending physicien and for use as the burial-transit	licai Examiner	cause. Enter Underlying Cause (Disease or injuly that initiated events resulting in death) Last C. Due to (or as a consequence)	nce of):						
.O. Box 6	0 0	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal dead 4 ☐ Pregnant at time of dead 9 ☐ Unknown	eath 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year					
۵.	sign sign	þ	Part II. Other significant conditions contributing to death but not resulti	ing in the underlying cause given in Part I. 23e. Did toba	icco use contribute to the cause of death?					
Records,	The law ite has b oage 2 sl	Completed		24a. Was an autopsy perform 1 □ Yes 2 2	prior to completion of cause of					
Vita	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one						
of	di s	1: To	1 Tes 2 Livo 1 Inpatient 2 LE	R/Outpatient 3 DOA Other: 4 Nursing Home 5 Residen 8b. Time of 28c. Injury at 28d. Describe how						
on	Attending I r death. ector; After by the funer	tion	1 ■ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	8b. Time of	,-,					
Division	el or Attendi s after death. il Director; A od in by the fu	Sertifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ee, larm, street, lactory, office 281. Location (Stree City or Town,	eet and Number or Rural Route Number, State)					
	To the Hospitei or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical Certification;	29a. Certifier (Check only 20 Medical Examiner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place, and due to the cau in and/or investigation, in my opinion, death occurred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)					
	To the To the complete	2	29b. Signature and title of conflier M M	165023	d. Date signed (Month, Day, Year)					
			30. Name and address of person who complyed cause of death (Item 2	Purdyst Cite 102 tarion	Md 21601					
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signatur APR 08 2010 Lines	un S. parke						
DU	MH 17 Rev 1/2	001	(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^y2010^{Year} Day **Physician** March 26, 8:05 PM M Richard B. Marsten /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring 3330 N. Leisure World Blvd #710 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 28, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ₹ M 2 □ F New York 84 1925 Director 019-22-3409 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Madical Examination at the rotified at 1 □Yes 2 □ No Director Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3330 N. Leisure World Blvd #710 20906 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: white Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) executive engineering 12 should be filed w h and Mental Hygies 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Jesse Marsten Rosalind Felder ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3330 N. Leisure World Blvd Silver Spring, MD 20906 Virginia Marsten/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Emeral Service Vicensee Ronald S. W. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Wade Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** oron ears Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes ficate has been sin, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 2 No After this certificate 2 No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Deatl 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

Medical

29a, Certifier

(Check only one)

Bru

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item, 23a) (Type, Print)
Butt, Feldman, MD 3305 N. Leiste Wend Blvd, Silver Spring

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

23958

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Frank Moore March 2010 6:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6423 Clifton Forge Circle Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 212-34-4845 Director 74 Sept 10, 1935 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ ... any injury or other traumatic events. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐Yes 2√☐No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21228 USA 6423 Clifton Forge Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐Yes 2 X No Specify: b1ack Be Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Õ 1aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Eugene Moore Sadie James Bonner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Moore/spouse 6423 Clifton Forge Circle Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servit eslicens ade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner teriosc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) □Yes 2 No 9 Unknown 9 Duknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

APR 08 2010

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiane 2011

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			for State Registrar	State of M	arylaric			te of			_	gierie Reg. No.		10	10000
	Dhysisi	an.	1. Decedent's Name (First, Mide	dle, Last)					_		2. Date of Dea		v	Year	3. Time of Death
	Physici /Medio		James Irvin M	itchell							March			2010	5 : 45 А м
	Examin	er	4a. Facility Name (If not instituti	_)					n of Death				of Death gomer	·v
***			15600 Hackney 5. Social Security Number					lver er 1 Year	_	er 24 Hrs.	I 9 Date of Birt		TOIL		ace (State or Foreign
	Funeral Director		578-34-4570 Usual Residence of Decedent	1 M 2 F	81	Yrs.	Months		Hours		8. Date of Birt (Month, Da July 20	y Year)	928	Count	sylvania
	aryland show	J.	10a. State 10b. Count	•		, Town or Lo								10	0d. Inside City Limits
	he M	ecto	MD Mont 10e. Street and Number	gomery	S:	ilver		ng ip Code				10a Cit	izon of V	Vhat Count	
	with t	Ö	15600 Hackne	v I ano			101. 2		0906			Tog. Oil	US		пуг
	ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S	3. 13.1	Nas Dec			Origin? (Sp	ecify Yes or No			e - America	an Indian.
980	be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or items 23a or 28a-f show event, if a Medical Eventing must be notified at	by Funeral Director	1 ☐ Never Married 2 ☒ Ma 3 ☐ Widowed 4 ☐ Divorce	Armed Forces? 1 X Yes 2 □ If Yes Give	?			ecify Cuba 2∭No			ecify Yes or No Rican, etc.)		Blac	k, White, e whi	tc.
2-0	72 hou	Completed	15. Decede (Specify only high	ent's Education nest grade completed)		16a. Dece	dent's Us kind of w	ual Occup	ation during m	ost of work	ing	16b. Ki	ind of Bu	usiness/Ind	ustry
2121	l within giene. r than	ошр	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I		use retired ales				ph	arma	aceut	ical
Maryland 21215-0036	be d al	To Be C	17. Father's Name (First, Middle Kenneth Mitch								e (First, Middle, Janet F			ne)	
lary	12.0 ha 7 Is	-	19a. Informant's Name/Relationship (Type. Print) Lynn Verboncoeur/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi								Code)				
di.	and fealth m 27		Lynn Verbonco 20a. Method of Disposition	eur/daughter	20b. PI	1121 lace of Dispo					Potoma			Oity or Tov	wn, State
Baltimore,	t. Pages tment of tant: If it		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (7										
Bal	permi Depar Impor any Ir		21. Signature of Funeral Service Ronald	S Wade, Di	ector			Anat Anat nore,			655 W.	Ba1	Ltime	ore S	treet
	Physician		shock or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
n. Rei	/Medical Examiner		-	Due to (or as	a consequ	ience of):									
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ience of):									
,	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience of):					-				
68760,	rificate be executed by physician and as the burial-transit	ledical		d											
O. Box 6	ath cer attendir for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic	pregnanc specify) _	;у					te of delive	ry Day Year
Э,	res that the de signed by the a be detached i	by Ph	Part II. Other significant condi	tions contributing to death I	out not resu	Ilting in the u	nderlying	cause giv	en in Pa	rt I.	23e. Did t	obacco i	use cont	ribute to th	e cause of death?
ord	w require been siç should b	ted t									1 🗆 '	Yes 2	No.	3 ☐ Prob	ably 4 ☐ Unknown
of Vital Records,	The faw cate has b page 2 sl	Completed									24a. Was autor perfo	osy rmed?		Were auto; prior to cor death? 1 □ Yes	psy findings available npletion of cause of 2 □No
/ita	slcian: The certificate rector, pag	Be	25. Was case referred to medic examiner?					044		ace of Deal	th (Check only o	ne)			
of	Physl this cr	은	1 Yes 2 No	Hospital: 1 ☐ Inpat 28a. Date of Inj		ER/Outpatier 28b. Time o			4 🗆	Nursing Ho	ome 5 Resi				/)
	d ing After fune	ation	1 Natural 5 ☐ Pend	/A do not h D	ay, Year)	Injury	M	28c. Injui Wor 1 🗆	k? Yes 2	□No	28d. Describe	iow irijui	ry occur	red	
=	Pig e	Certification:	3 ☐ Suicide 6 ☐ Could	mined 28e. Place of In	jury - At ho tc. <i>(Specif</i> y	me, farm, str	eet, facto	ory, office			28f. Location (. City or To	Street ar vn, State	nd Numb e)	er or Rura	I Route Number,
	Hospital 24 hours a Funeral I etely filled	Medical (29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physician: To the best al Examiner: On the basis and manner s	of examinat	wiedge, deat tion and/or in	h occurre vestigati	ed at the ti	me, date	and place death occur	, and due to the rred at the time,	cause(s	s) and m d place,	anner as s	tated. the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certif				2	9c. Licens	se nu <i>m</i> be	er e		29d. Da	ate signe	d (Month, i	Day, Year)
			Vacan ti	myay				D23	308			AP	RIL	1,20	OID
			30. Name and address of person	in the completed cause of RIEW, MD 2010 Series	death (Item	23a) (Type,	Print)	DR.	#410	00 E	ETHESI	DA,	MI	0 200	817
Π	Sta Registr		31. Date filed (Month, Day, Yea	2010 (32. Regist	rar's Signat	ture pay	الما								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #14, per Fh G902 4/20/10 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 2 2010 LILY **MILLER** 2:48 р м /Medical 4a. Facility Name (If not institution, give street and number)
Greater Baltimore Medical Center Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson 8. Date of Birth (Month, Day, 1958) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 9. Birthplace (State or Foreign 1□ M 2 🙀 F Months Days Hours Min. 51 Vrs Director 141-52-4386 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar is ust be profilled at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 No Maryland Baltimore County Parkville 10e. Street and Number 10g. Citizen of What Country? 7406 Park Drive 21234 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 No Specify White Black Be Completed by 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Howard County School Elementary/Secondary (0-12) College (1-4or 5+) Special Education Teacher System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Francis Riddick Bertha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha M. Taylor permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr (Mother) 112 12th Avenue, Patterson, New Jersey 07501 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel Grove Crematory 4/12/2010 Totowa, New Jersey 21. Signatur / Euney Service Certain V. Lawson 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212 auson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Reart ongestive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nfiltrative if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cel lasma signed by the attending physician and abe detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 O 1 Yes 2 No 3 Probably 4 Unknown Completed peen (24b. Were autopsy findings available prior to completion of cause of death? story 24a. Was an has σ autopsy this certificate perform 1 □Yes 2 No 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ patient 2 ☐ ER/Outpatient 3 ☐ DOA after death. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marie hallem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Street Maria No. th 10005001 6701 31. Date filed (Month, Day, Year) APR 0 8 2010 32. Registrar's Signature State Registrar

1	0-02585

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arl Junior Nes	seiro	OCIT S' 1- For State Registrar	tate of Maryla		artment of <i>rtificate of</i>		d Mental	Hygiene	Reg. No.	201	0 1080	40
Physici		1. Decedent's Name (First, Midd	lle,Last)					2. Date of D Month		Year	3. Time of Death	-
Medical Exami	iner	Earl J Nessel 4a. Facility Name (if not institution		mb or\		4h Cihi Taum as	l coation of Do	April 2,	2010	c. County of D	1025 hrs	_
		9104 Baltimore Stree		iliber)		4b. City, Town, or l Savage	Location of Dea	auri		Howard	eaui	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year		rs. 8. Date of	Birth(MM		. Birthplace (State or oreign	-
Director		213-54-0597	1XM 2F		61 Yrs	Months Days	Hours M	lin. 10/0	8/19	48	Country) MD	_
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion					10d. Inside City Limit	ts
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he Maryland or 28a-f sho ified at once.	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What	Country?	_
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eath wi items ust be	uneral	11. Marital Status 1 XX Never Married 2 M	arried Armed Fo			s Decedent of Hisp es, specify Cuban,			No-	14. Race - A White, et	merican Indian, Black, tc.	
rs after de ural", or miner m	by Ft	3 Widowed 4 Div	orced If Yes, Give Yea or Dates:	2 ₹ ጃ No	1	Yes 2X No	specify:			Specify: W	hite	
hours a	T	15. Decedent's Education (Spe	cify only highest grad			t's Usual Occupati ost of working life.			16b.	Kind of Busine	ess/Industry	
36 hin 72 e. than "	Complete	Elementary/Secondary (0-12)	College (1	-4 or 5+)	Floor	Sander			Co	onstruc	tion	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Con	17. Father's Name (First, Middle	, Last)				8.Mother's Nar	ne (First, Middle				-
121 d be fi fental I	o Be	Earl Nesselro			Table Marie	A 1.1 (5)		Catheri				_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shi injury or other traumatic event, the Medical Examiner must be notified at once	ĭ	Edna M. Murra				Address (Street Woodsong				•	state, ZIp Code)	
e, N 1 and 1 Health Fitem r trau		20a. Method of Disposition				ition (Name of cerr	netery,	Date			y or Town, State	-
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Baltimore, permit. Pages 1 ar Department of Her Important: If ite		21 Signature of Funeral Service	Licensee								lome, P.A.	
Physician		Jaken Siles Part I. Enter the disease, or	complications that ca	M0105 aused the death	. Do not enter the	3 Talbot e mode of dying, s	t Ave.,	Laurel or respiratory a	rrest, sho	20707 ock, or heart	Approximate Interva	al
/Medical	H	failure. List only one cause Immediate Cause (Final disease		sclerot	ic card	liovascu1	ar dise	ease			Between Onset and Death	t
Examiner		or condition resulting in death)	Due to (or as a									
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence o	f):							-
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ecuted and transit		events resulting in deathy Last	d									
60, tte be exe hysician a	Medical	X UNPENDED	AMENDED 23a, 2	7.perm,	E_g902	4/30/10	TT					
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23C. II yes, C	diconie oi pregi	Ilalicy	al death 3	Ectopic preg	nancy	230	d. Date of deli Month	very Day Year	
Box 6876 e death certificate the attending physical for use as the	hysician/N	past 12 months?	(nour	ant at time of de		ner (Specify)						
D. B. the de by the Iched f	Phy	Part II. Other significant condit	9 Olikilo		esulting in the u	nderlying cause gi	ven in Part I.	23e, Did	tobacco	use contribute	e to the cause of death?	-
P.O. res that to signed by be detac	d b							1 🗆 Y	es 2	No 3 []	Probably 4 Unknown	
Records, The law requir ficate has been s	ompleted							24a. Wa auto	s an opsy		a autopsy findings available to completion of cause of	e
Recc The lay cate ha	Ë				_			per 1 ✓ Yes	formed? 2 N	death		
tal Recian: The certificate	Be	25. Was case referred to medica examiner?	Hospital: 577				of Death (Chec		7			_
of Vital ng Physician: ufter this certifuneral director	은	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,		ER/Outpatient 28b. Time of Ir		at Work?	ing Home 5		nce 6 ✓ 0	ther: Scene	_
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Division ospital or Attendi hours after death, ineral Director: /	Certification:	3 Suicide 6 Coul	d not be	of Injury - At ho	ome, farm, stree	t, factory, office bu	ilding, etc.	28f. Location or Town,		ind Number or	Rural Route Number, City	7
sspi hou iner		4 Homicide	mined (Specify)			- 1 - 1 - 1 - 1 - 1 - 1 - 1						_
To the Hospital within 24 hours To the Funeral	Medical		nysician: To the best miner: On the basis o	f examination ar	ge, death occurr nd/or investigati	ed at the time, dat on, in my opinion,	e and place, ar death occurred	id due to the cai at the time, dat	use(s) an e and pla	id manner as s ice, and due t	stated. o the cause(s)	
5 .¥ 5 8	Ž	29b. Signature and title of certifie	and manner st	ated		29c. License	number		29d. (Date signed (Month, Day, Year)	-
		Mayorte (me You	U		O.C.N	1.E.		Apri	il 3, 2010		
ok pere		30. Name and addess of person Margarita Korell MD.	who completed cause Assistant Med	·		enn Street, Ba	Itimore MD	21201				
St	ate	31. Date filed (Month, Day, Year)	32. Rec	gistrar's Signatu	ire .		.arriore, IVID					-
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State of Maryland / Department of Health and Mental Hygiene-

Certificate of Death

Physicia /Medic Examin	a
Funeral Director	

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Vital

Division of

1. Decedent's Name (First, Middle, Last, 2. Date of Death 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year Birthplace (State or Foreign Country) Days Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 des 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√No 3 Vidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+ Elementary/Secondary (0-12) Father's Name (First, Middle, Last) Be Daughter 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 Is
any Injury or other trau ohnson 20a Method of Disposition Burial 2 ☐ Cremation 3 ☐ F 3 Removal from State 21. Signature of Funeral Service Licensee NO/3 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ALZUEIMER'S DEME NTA /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗆 No 1 Tyes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 🗌 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 2898 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO 21239 5601 LOCH RAVEN 31. Date filed (Month egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 0804 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **PULLIAM** II $AD^{MO}I^{th}4, 2010^{th}$ **CMAR** VERNICE 12:54A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore St Joseph Medical Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral **XX** M 2 □ F 76 Months Days Hours Min. 213-30-2999 June 24.1933 North Carolina Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits Examiner must be notified at 10c, City, Town or Location Director 1 Yes 2 XX No Maryland Baltimore Towson 10f. Zip Code 10e. Street and Number P 10g. Citizen of What Country? 23a Funeral 21204 USA 17 Ruxview Court #302 items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces XX Yes 2 No Korea Black, White, etc. ō 9 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White "natural", 3 Widowed 4XX Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " College (1-4 or 5+) Elementary/Seconday (0-12) Public School Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Omar Vernice Pulliam Lucille Virginia Phelps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra DTR 124 Hilldale Court Claymont Delaware 19703 Lucienne M Pulliam Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) XX Burial 2 ☐ Cremation 3 ☐ Removal from State April 10,2010 BelAir Memorial Gardens BelAir, Maryland 4 Donation 5 Other (Specify) nature of Funeral Same 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death use on each line. Immediate Cause (Final Kneumonia Priysician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 🗌 No 9 Unknown the the 9 Unknown P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 2 No 3 Probably 4 Unknown been signature should the Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? certificate | 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) director examiner? 2**XX** No. 1 XXInpatient 2 □ ER/Outpatient 3 □ DOA Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 1 XX Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t 5 Pending 1 Tes within 24 hours after death

To the Funeral Director; A
completed filled in by the f Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00639 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

APR 0

8

Imran E Sidofigi 7601 York Road Towson, Maryland 21204

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yea **Physician** 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ave If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Year) **₩** 2 □ F Days 217-50-633 Director m Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Mudical Expris with ust be notified at 1√Pes 2 No Funeral Director min IMOre 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21276 DCKKAVE permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hatural", or items 23s any Injury or other traumatic event, the Medical Extrainer and once. 12. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?

12. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?

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19. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)

19. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ੬ 3 Widowed 4 Divorced BIACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Thuck Servic grad C None 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ (Type. Print) 19a Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, 17 ty or Town, State, Zip Code) 31110, mi) Place of Disposition (Name of cemetery, crematory or other) Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation, 5 Other (Specify) 21. Sign Jur Fuperal Service Licensee 22. Name and Address of Facility 70, m) 2121 3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NOTHIL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, physician the burial Completed by Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? After this certificate 2 No 1 Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled i TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State APR 08 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

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	Physicia	1/	Patricia	Mabe1		Rispoli		April	5 ^{Day} 20	Year 10	2:00PM
	Medic Examin		a. Facility Name (if not institution, give st			4b. City, Town, or Lo	cation of Death		4c. County	of Death Arunde	.1
Sept.			1306 Donald Aver		Inné histholaul	Severn If Under 1 Year If	Under 24 Hrs.	8. Date of Birth		9 Birtholac	ce (State or Foreign
	Funeral Director		142-30-8037	7. Age (in yrs.			Hours Min.	8. Date of Birth (Month, Day, Aug • 2 •	^{Year)} 938	Country	New York
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	th with ns 23 must	Funeral Director	1306 Donald Avenu	12. Was Decedent Ever in U	IS 13 V		anic Origin? (Spe	cify Yes or No-		e - American	Indian,
·^	or iter	by Fu	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No		Vas Decedent of Hisp f Yes, specify Cuban, I		Rican, etc.)	Blac	ck, White, etc	;.
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Maryland 21215-0036	12 should lith and M 27 is mar r traumati	П	19a. Informant's Name/Relationship (Type Mr. Martin Rispol:			Donald A		Severn	, MD 2	1144	
ē,	F Healt F Healt Item 2		20a, Method of Disposition	20b.	Place of Disno	osition (Name of matory or other place)		Date	20c. Location	•	
E	Page nent o		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State) MD	Vator	ons Cemeter	rv ! 04-0	9-2010		sville	
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4			shock, or heart failure. List only or immediate Cause (Final	ne cause on each line.	10. 11.70	eirand			13828		Interval Between Onset and Death
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		ate	31. Date filed (Month, Day, Year)	32. Registrar's S	gnature /	النا					
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Physicia	ın/	Registrar 1. Decedent's Name (First, Midd Deborah Row	le,Last) Dobra			Dealii		2. Date of Dea	eg. No. 💪 🔱 th	3. Time of Death	
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Funeral	-	8716 Greenfield Cour 5. Social Security Number		7. Age (In yrs. I	Odenton Isst birthday) If Under 1 Year If Under			e Is Date of Bir	Birthplace (State or		
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Donaldson Funeral Home & 1411 Annapolis Road Oden Physician Physician 23a. Pat/l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest fature. List only one cause on each line.						est, shock, or heart	Approximate Interval Between Onset and				
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Box 6876 e death certificate the attending phy ed for use as the 1	Siciar	past 12 months?	4 Pregna	nt at time of de	ath -	al death 3 L er (S <i>pecify)</i>	Ectopic pregna	ancy	Month	Day Year	
Bo te deat the at the for	Phys		9 Unknov								
Division of Vital Records, P.O. Box 6876 rate or Attending Physician: The law requires that the death certificat rs after death. The law requires that the death certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the	집	Part II. Other significant conditi	ons contributing to	death but not re	esulting in the ur	nderlying cause giv	ven in Part I.			e to the cause of death? Probably 4 V Unknown	
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Division of Vital Records, P.O. Box within 24 hours after death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the arte completely filled in by the funeral director, page 2 should be detached for I	edical	(Check only	nysician: To the best miner: On the basis of	examination ar							
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10 m Lin					O.C.M	l.E.		April 2, 2010			
b		30. Name and address of person		•	•	D 0: : :	D - W:	D 04001			
90		Donna M. Vincenti, MI		edical Exam	50.0	Penn Street, I	Baltimore, M	21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10a-c,e,f per inf g913 3-30-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 1:20 PM Benedict L. Rosenberg 421011 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Levindale Hebrew Geriatric Ctr Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 2, 1920 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F Mary Land 213-01-1660 Director 89 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene.
ortant: If them 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits Florida Palm Beach Palm Beach Baltimore Director 1X Yes 2 No MD 10e. Street and Number 2774 S. Ocean Blvd. # 701 10f. Zip Code 10g. Citizen of What Country? 33480 21208 USA Slade Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify. þ 44-45 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) salesperson insurance d 2 should be filed w th and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Isadore Rosenberg Hortense Camille Lang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Slade Avenue #817 Baltimore, MD 21208 Babette H. Rosenberg/spouse permit. Pages 1 a
Department of Hee
Important: If Item
any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Euneral Servi 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director ma Baltimore, MD 21201 23a. Part1. Part1. Enter the disea ..., or shock, or heart failur ... List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) glioblastoma Physician multitorme months /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or se a consequence of) Examiner burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an autopsy performed? 2 □ No 1X Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ဥ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053928 04/05/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURAIYA BELLIA BEGUM, MD , MD - 2/215 31. Date filed (Month, Day, Year) APR 08 2010

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dorothy Sullivan 4/6/2010 12:35art Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number)
Maples of Towson Assisted Living 4b. City, Town, or Location of Death TOWSON MD **Examiner** 7. Age (In yrs. I 94 Social Security Number If Under 1 Year If Under 24 Hrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2XX 212-01-3692 Months Days Hours Month, Day, Year) 11/19/1915 Director Usual Residence of Decedent show at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified MD Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 204 E. Joppa Road # 1016 21286 USA er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 o Specify: If Yes, Give Year or Dates. 3 ☐ Widowed 4 ☐ Divorced Specify. white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Real Estate Be 17. Father's Name (First, Middle, Last)

Roland M. Long permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) ည Dorothy C. Burdette 19a. Informant's Name/Relationship (Type, Print) J. Richard Silk / POA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10806 Stevenson Road, Stevenson MD 21153 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 M Cremation 3 Removal from State Ardent Crematory or other pu 4/9/2010 Hanover Maryland 4 Donation 5 Other (Specify) ure of Fo. ral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Orset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Concer disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): this certificate has been signed by the attending physician al director, page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Petal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? Month Day Year 2 No Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unetheral carrier 1 Ves 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed' death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral in the fune 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospita within 24 hours To the Funeral

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADD LED L. LOPEZ MD.

31. Date filled (Month, Day, Year)

32. Relistrar's Signature and Address of Paristrar's ddress of Paristrary Address of Pari

12

20 PEZ ND. 8415 Gellona Lane
32. Registrar's Signature of

D14811.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9200 AM 2010 Pau1 Shafer Eugene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner en BUY シェストイ Baltimore Washington Medical Center If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Days Hours Country) 84 **Director** 234-32-8267 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1441 Gordon Drive 21061 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Auto & Truck Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Shafer Frank McKinley Dessie Hauger and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mrs. Mary Shafer / Wife 1441 Gordon Drive Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o 1 🔀 Burial 2 🗀 Cremation 3 🗀 Removal from State Sacred Heart of Jesus: 04-12-2010 4 Donation 5 Other (Specify) Dundalk, MD 22. Name and Address of Facility Signature of Funeral Service Licensee 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physicials 1 disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine il any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Day to (unes a consequence of) for use as the burial-transi the death certificate be executed the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death 1 Yes 2 g 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the e completed filled in by the funeral director, page 2 should be detached to g Unknown P.0 that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn Hospital or Attending Physician: The 2 No ☐ Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Suppatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural 2 🗌 No Investigation
6 Could not be Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one 29b. Signatur nd title of c Artifier signed (Month, Day, Year) 0 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) mi

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 08

32. Registrar's Signature

10-02667 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Samuel Leroy Slacum State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 5, 2010 2040 hrs Medical Examiner Samuel Leroy Slacum 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 2020 1/2 Cresswell Road Brooklyn 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral Months Days Hours Director 216-60-6729 56 08/15/1953 countr Mary land 1 M 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. MD Anne Arundel 1 Yes 2 X No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 Cresswell Road 21225 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes White 1 Yes 2 No specify: 4 X Divorced If Yes, Give Year Specify: 3 Widowed ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 10 Carpenter Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marcellus Slacum Mary Slacum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Brennerr /Sister 7210 Darby Downs, Unit B, Elkridge, MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Ardent Cremation Services |04/07/2010 |Hanover, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, St.N, Hanover, MD 21076 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each lir /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed sician/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Live birth Fetal death 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 交 1 Yes 2 No 3 Probably 4 V Unknown Chronic obstructive pulmonary disease Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. funeral director, Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 DOA 1 V Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day, Year) 1 V Natural 5 Pending the To the Funeral Director: 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 (Check only one) 2 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

OCMF 2006

DHMH 17 Rev 1/2001

arks

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 6, 2010

Melissa Brassell, MD

31. Date filed (Moath, Day Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a.ptI, II, 25, 27-28f, perME, G907, 9/14/2010, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year ANIL-05-2010 **Physician** CAROL 5 M 17H 13.30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAURE OF GRACE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 23, MEMORIAL HOSPIGAL HARFORA 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1 □ M 2 🖫 F 213-46-2604 1946 West Virginia **Director** 63 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location or 28a-f show 10d. Inside City Limits Examiner must be notified at Director XXYes 2 □ No Maryland Aberdeen Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 151 East Deen Avenue 23a 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify à Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ith and Mental Hygier
27 Is marked other the traumatic event, ins. 12 0 civil service US Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Dewey Stout Thelma Gavle Roe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If Item 27 any Injury or other the once. Charles R. Smith, Jr. (husband) 151 E. Deen Ave., Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify)entombment Harford Memorial Gardens 4/10/10 Aberdeen, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Cutaneous Necrotizing Vasculitis Approximate Interval Between Onset and Death Immediate Cause (Final Physician STREPTOCOCCAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II Other significant conditions contributing to death but not result in the underlying cause given in Part I. Acc tam nopnen loxixity the Hepa c Necro s, Pneumonia 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 SHUnknown Rypertensive Atherosclerotic Cardiovascular Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ►No Cocre 24a. Was an certificate has birector, page 2 s autopsy performed? 1 Syes 2 □ No LE CTASIS To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 🔏 Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nation 2 I ER/Outpatient 3 I DOA Certification: To funeral 28a. Date of Injury

Fnd (Month, Day, Year) 27 Manner of Death 28b. Time of Injury 28d Describe how injury occurred Subject ingested acetaminophen 1 Natural 2 NAccident 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 X No April 4, 2010 Unknown 6 ☐ Could not be 3 □ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Fnd:151 East Deen Ave. Aberdeen, Maryland determined 4 Homicide Fnd: Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 21338 Name and a press of person who completed cause of death (Item 23a) (Type, Print) HARPOLD STEMORIAL GOSPITAL HAVING DE ERACE SWEATATA 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 0 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per DVR 9902 4/8/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month Betty Jandlin 17 15 04 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard **Howard County General Hospital** Columbia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 🗆 M 78 Director 239-46-1731 NC Dec 9, 1931 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.
n 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10d. Inside Cify Limits 10a. State 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygene. Important: if the 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Merice Examine must be notified as 1 □Yes 2 No Director NC Onslow North Topsail Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40 Sailview Drive 28460 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 🖽 No Specify: þ If Yes Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Customer Service Banking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Bracher Margaret Ricks ပ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billy Sandlin 40 Sailview Drive North Topsail Beach, NC 28460 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 08, 2010 4 ☐ Donation 5 ☐ Other (Specify) **Onslow Memorial Park** Jacksonville, NC Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part 1. Let the dise (s. r. r complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final **Physician** archithmia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be execute been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregpant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has I 2 No 1 □Yes 2 HNO 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. 120066515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kawat Columbia, MD 21044 10710 Charter Dr. Ste 310 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Casimar Anthony Szczech Medical Apr 6, 2010 5:19 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Windsor Mill **Baltimore** 7162 Fairbrook Rd Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min Yrs **Director** 185-46-2374 PA Mar 31, 1961 Usual Residence of Decedent 28a-f shov 10a State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s er must be notified 1 Yes 2 No MD Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7162 Fairbrook Rd 21244 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 14. Bace - American Indian. Black, White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 2X No Specify "natural" 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed thent of Health and Mental H rtant: If item 27 is marked ot ijury or other traumatic ever ပ Alfred Anthony Szczech Marie Mildred Piechocki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance M. Szczech Sister 7162 Fairbrook Rd. Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Apr 09, 2010 Glen Burnie, MD Atlantic Crematory, LLC Funeral Ser 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final De vous Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital: 2 No 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Amesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) I Director: After the d in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Pending work? Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) 32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Tkaczuk, Edmund P., MD 405 Frederick Road, Suite 100 Catonsville, MD 21228

D34951

29d. Date signed (Month. Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 6, 2010 8:45 A M MARGARET LEONA SNYDER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7, Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. July 12, 1921 Maryland Director 220-07-6278 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits within 72 hours after death with the Maryland 1 Yes 2 StNo Maryland | Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1131 Poplar Grove Road 21154 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2 XNo Specify: 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Line Worker 12 Shoe Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Regina Alkire Vincent Ambrose Diggs and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1131 Poplar Grove Road, Street, Maryland 21154 Maria Ann Snyder / Daughter Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Other (Specify) Air Memorial Gdn 4-10-10 Bel Air, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ANTERY DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence of that initiated events Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE PULMONARY DISEATE 1 ≥ Yes 2 No 3 Probably 4 Unknown MEZYTOS J 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPOTHXRD IDISK performed 2 🗆 No 1 Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 뎯 1 🗌 Yes 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ♥Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner-To the Sest of my hippelings, draft contained at the fine, date and plane, and due to the neurosia and manner as state 29b. Signature and title of certifier APRIL 6, 2000. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW WONTH MM MW 35 FULFORD AVE. BEZMIR, MD 21014 32. Registrar's matur State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day \mathbf{P}^{M} Madeline Snyder 2010 9:50 APRIL 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F Months Days Hours Min. 87 Director 216-16-8008 Apr 10, 19122 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits in feating and missing the property of thems 23a or 28a-f show other traumatic event, the Macilian Experiment is used by marting at 1 ☐ Yes 2√∑ No Director MD Worcester Berlin 10e. Street and Number Hood 81 Robin Hool Trail 10f. Zip Code 10g. Citizen of What Country? 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 21215-0036 If Yes Give 1 □Yes 2 💢 No Specify: ģ white Specify: 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than own home homemaker Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Zell John Emmett Morse ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $81\ Robin\ Hood\ Trail\ Berlin,\ MD\ 21811$ 19a. Informant's Name/Relationship (Type, Print) Park Snyder/spouse permit. Pages 1 and Department of Healt Important: If Item 27 any injury or other 1 once. Baltimoré, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 Other (Specify) S. Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Ronald ans Baltimore, MD 21201 23a. Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** toute myocardio disease or condition resulting in death) clai /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Deleri 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Sinusi 2 No 1 ☐ Yes 2 ☐ No cute 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

rie

31. Date filed (Month, Day, APR 08

20907

6705 N Chades Street, Baltimore, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 0230AM April LEONARD SAMUEL SHERMAN 05 2010 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE Bal Hospita St. Agnes timore 8. Date of Birth 12/7/1953 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Number Months Days Hours MD 56 213-64-6553 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No OWINGS MILLS MD BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21117 USA 4 REGALIA COURT, APT. D 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No WHITE Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) RETAIL BUYER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RUTH SHERMAN SIDNEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIMBER WAY COURT, REISTERSTOWN, MD RUTH SHERMAN/MOTHER 20b. Place of Disposition (Name of cemple Work Bata A PACHA Slace) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 4/7/2010 RANDALLSTOWN, MD CHESED CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} SOL LEVINSON & BROS., I 8900 REISTERSTOWN ROAD, PIKESVILLE, MD INC. 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pleurak disease or condition resulting in death) (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 NO 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical **Examiner** Examiner law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantines must be notified at

Baltimore, Maryland 21215-0036

68760

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Division of Vital Records,

Hospital or Attending Physician: The

certificate

After this

24 hours after death e Funeral Director:

within 24 hours a

To the Funeral D

buri - I-transit funeral director,

Physician/Medical 2 Completed Be Certification: To

3 Suicide

29a, Certifier

taria

31. Date filed (Month, De

4 Homicide

(Check only one)

29b. Signature and title of certifier

Amirag

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

April 05 2010

Coton Ave. Baltimore MD 21229

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruth Marie Tramposch Abril 201^Y0° 11:00 PM Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Year) 1926 Days Min. 1 □ M 2 🛣 F Hours March Day 110-18-3049 84 New York Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itemated other trainmain. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Towson 1 Tyes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6451 North Charles Street 21212 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Court Reporting Freelance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Kraker Rose Kaps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane M. Runciman, Daughter 711 Gittings Avenue, Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cremation Society of PA 04/07/2010 Harristurg, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fure a Harman Cremation Society of PA e Licensee 22. Name and Address of Facility 4100 Jonestown Road, Harrisburg, PA 17109 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or impury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Id be detached fo 1 | Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown page 2 should certificate has been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this 28a. Date of injury (Month, Day, Year) 27. Manner of Dea h 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury injury work?
1 Yes 2 No 5 Pending I Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical Careful Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signat

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 umma TISTL 420 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARLUNDEL NIER BATTIMONE WASHINGTON MEDICAL CENBURNIE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. Maryland 0842 Director 62 52 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and if if item 27 is marked outher than "natural", or items 23a or 28a-f sho and the transmise event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2.8 Carroll Rd. 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Plumber BGE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Tiszl Eileen A. Kinder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola McKinney - ex-wife 10 W. Railroad Ave. Ridgley, MD21660 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4/12/2010 Baltimore, MD 22. Name and Address of Facility GJ Gonce Funeral Home
160 Birriogo Dr Pasadena, MD 21 21. Signature of Funeral Service Licensee 23a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ OBSTRUCTIVE PULMONARY DISEASE CHRONIC disease or condition resulting in death) Years Medical Due to (or as a consequence of) **Examiner** cancer year luna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? þ Records, To the Hospital or Attending Physician: The law requires Completed 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t autopsy this certificate 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) April 06,2010 D0069554 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Nadia

31. Date filed (Month, Day, Year)

Chaudhi

MD

6 V

301

Hospital Drive, Gen Burnie, MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / De	partment of Health and ertificate of Death		0010 10000
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. N	3. Time of Death
	Physici /Medio		IDA R. THALL		Month 4	2010 9:15 P ^M
a.	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	th 4	c. County of Death
-	Francis		Marley Neck Health and Rehab 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdi	Glen Burnie		Anne Arundel 9. Birthplace (State or Foreign
	Funeral Director		217 12 3074 1 M 2 F 87 Yrs	Months Days Hours Min	(Month, Day, Yea	22 Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Maryk f sho	ţō		d Beach		1 ☐ Yes 2, ☑ No
	h the or 28a	Director	10e. Street and Number	10f. Zip Code	10g. (
	23a c	ral	7815 Harbor Drive	21226		U.S.A.
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evarning must be notified at once.	by Funeral	11. Marital Status 1. Marital Status 1. Was Decedent Ever in U.S. 1. Mever Married 2. Married 1. Mever Married 3. Morried 1. Mes Decedent Ever in U.S.	 Was Decedent of Hispanic Origin? (§ If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify: 	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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m	permi Depal Impol any ir		12/5	169 Riviera Dr.	Pasader	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		c or respiratory arrest,	Approximate Interval Between Onset and Death
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	in		30. Name and address of person who completed cause of death (Item 23a) (Typ		Mara a real	1 - 10 - 10 11 15 1
	Sta		Haitya (Nopra MD COOK AGE) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	of the stexs!	FIVIY KYO	US MD 21401
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year Jean linsley 2010 /Medical ADVI 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Howard County General Hospital** Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 M 2 X F 226.42.6993 Director Virginia Mar 7, 1937 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating is at the reliting at anothes. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10805 Hilltop Lane 21044 Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be J. Rhoades Tinsley ည Ruth Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Leo Usilton - spouse 10805 Hilltop Lane Columbia, MD 21044 20a. Method of Dispo≰ition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Atlantic Crematory, LLC Apr 06, 2010 Glen Burnie, MD 21. Sonature Funera Service Licer 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MO0591 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner bilatern on en mona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-transi multiple scherusis Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl for use as t IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) hed by the a ☐Yes 2 ☐No 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown been Respiratory 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has was autopsy performed? Myocordia 1 ☐ Yes 1 ☐ Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Ne 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 🗆 Yes 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

WAW

31. Date filed (Month, Day, Year) APR 08 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

He Gen Horbita BUNGE 32. Registrar's Signature

and manner stated.

29c. License number

43-662

29d. Date signed (Month, Day, Year) April 5, 2010

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month $\overset{\text{Day}}{2} \underline{0} \underline{10}$ Eugene C. Vaughn Jr April 6:40 AMM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince George's Hospital Cheverly Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Yea ct 30, 1 1 🕅 M 2 □ F Months Days Hours Min Dountry) 1abama 82 Director 421-22-3878 Oct Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Tes 2 No MD Prince George' Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3402 25th Avenue 20748 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. black Specify: 3 Widowed 4 Divorced "natural" Completed 150-52 er than "natur, the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Medonce. Elementary/Seconday (0-12) College (1-4 or 5+) counselor juvenile services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eugene C. Vaughn Sr Wilhelmina Mercedes White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nildred Vaughn/spouse Mildred 3402 25th AVenue Temple Hills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State netery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) 21. Sign ture Funeral Service State Anatomy Board 655 W. Baltimore Street Director _MD_ 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death PANCREATIC Ph_sician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) signed by the should be detached g Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy funeral director, page 2 certificate 1 Yes 2 No Yes 2 No Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 📈 No |မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify Division of 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifie 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) D69214 4/2/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr. Cheverly, MD 20785 Arpana Mahalingashetty P.G. Hospital 31. Date filed (Month, Day, Year) State APR 08 Registrar

			Amend #2, per MD g902 4/ State of State of Registrar			All Copies Mental Hys	s Are Legible giene	
	Physici Medi		State Registrar 1. Decedent's Name (First, Middle, Last) KEVI N	Ce, V A (4	rtificate of Death	2. Date of Dea	ath 06	3. Time of Death / 23 0 M
-	Exami		4a. Facility Name (if not institution, give street and num 304 Baylor Road		4b. City, Town, or Location of Deat		4c. County of Dea	e Arundel
	Funeral Director		5. Social Security Number 146–50–1587 6. Sex 1 M 2 \square F Usual Residence of Decedent	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birt (Month, Day 08/13/	th 9. Bir y Year) Co	thplace (State or Foreign untry) NJ
	n the Maryland a or 28a-f show be notified at	Funeral Director	10a. State 10b. County MD Anne Arunde 10e. Street and Number	10c. City, Town or Lo	Glen Burni	e	10g. Citizen of What Co	•
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once.		304 Baylor Road 11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced 12. Was Dece Armed For 1 X Yes If Yes, Giv	2 ∐ No	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	U • S 14. Race - Ame Black, White Specify:	
21215-0036	l within 72 hou ygiene. her than "natu t, the Medical	Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-12)	(Give	dent's Usual Occupation kind of work done during most of wo. O NOT use retired) Loss Prevention		16b. Kind of Business	Industry Valmart
Maryland	should be filed within and Mental Hygiene. is marked other tha aumatic event, the N	To Be	17. Father's Name (First, Middle, Last) Clyde Vail		Murie	el Hahn	Maiden Surname)	
	and 2 shored the shore		19a. Informant's Name/Relationship (Type, Print) Mrs. Patricia Vail / wi 20a. Method of Disposition	fe 304		Glen Burn	nie, Maryla	nd 21061
Baltimore,	permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other trated		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Atlantic	natory or other place)	Date 08/2010		ie, Maryland
ä	permi Depar Impor any ir		23a. Part 1. Sater the disease, or complications that c	MO1357 S	ingleton Funeral	& Cremat	tion Servic	es, P.A.
-4	mysician/ Medical Examiner		shock, or heart failure. List only one cause on ear immediate Cause (Final disease or condition resulting in death)	th line.	AL STRUMAL T		1	Approximate interval Between Orset and Death
/ 00	e be executed lysician and le burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	or as a consequence of): or as a consequence of):				
. Box 68760	The law requires that the death certificate be or attending bhysician bage 2 should be detached for use as the burn	Physician/Medica	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
ords, P.O.	v requires that the book of the contract of th	<u> </u>	Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause given in Part I.	1 🗆 Y	bacco use contribute to	obably 4 🗆 Unknown
Division of Vital Records,		Be Completed	25. Was case referred to medical		26. Place of Death (Che	24a. Was a autops perform 1 Tyes	sy prior to death?	opsy findings available completion of cause of
VII.	Physicia this cer al direct	일 일		npatient 2 DER/Outpatien	Othori		ence 6 Other (Speci	fy)
ion of	Attending Physician: If death. cotor: After this certific by the funeral director,	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	f injury 28b. Time of injury injury	28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe ho	ow injury occurred	
Divis	Hospital or Attenc 24 hours after death Funeral Director: /		4 Homicide determined 28e. Place buildin	of Injury - At home, farm, stre g, etc. <i>(Specify)</i>		City or Town		
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best only one) 3 Certifying Nurse Practioner: To	of examination and/or invest	igation, in my opinion, death occurred a leath occurred at the time, date and pla	at the time, date an ice, and due to the	nd place, and due to the c cause(s) and manner as	ause(s) and manner stated stated.
9	7 .		29b. Signature and title of certifie	tentan	29c. License number 2/43	8 1	29d Pate signed (Month)	27 2010
1	-0:-		MICHARY LAPENT	of death (Item 23a) (Type,	EFENSE HIGHWA	AN	NAPOLIS	M02401
	Stat		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month VESNOVSKY 2:47 PM KALMEN 2010 April Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Baltmore Hospital of Baltimore N/A If Under 1 Year If Under 24 Hrs. 6. Date of Birth Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Country) UKRAINE 107T3PT932 219-43-4617 77 Director Usual Residence of Decedent fshow Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Completed by Funeral Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6948 MARSUE DRIVE, APT. 2A 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes : 1 Yes 2 No Specify. WHITE 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) within Elementary/Seconday (0-12) MECHANICAL ENGINEER MACHINERY Be filed \ Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be VESNOVSKY SOFIA KOGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IGOR VESNOVSKY/SON 7214 DENBERG ROAD, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State HAR SINAI CEMETERY 4/7/2010 OWINGS MILLS, MD 4 Donation 5 Other (Specify) re of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one base on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition resulting in death) Medical Due to (of as a consequence of) Examiner Ascites Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) auss (Discase or linjury the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) 2 No 9 Unknown g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t
 24 hours after death.
 Funeral Director: After this certificate has been sinn 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) REL-000 U 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Vesnovsky

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10826 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ IAM 0705 M Medical 4a. Facility Name (if not institution, give street and number **Examiner** Town, or Location of Death 4c. County of Death 255 Sburc KOAd ASAdeN A 8. Date of Birth (Month, Pay, 3 14 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 **⊠** M 2 □ F Months Hours Min Maryland 5244 218 14 Director 91 1909 Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MDAnne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 255 Asbury Road 21122 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2. No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Pittsburg Elementary/Seconday (0-12) College (1-4 or 5+) Janitor Plate & Glass Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ John Wall, Fuller Minnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 255 Charles Uhden - nephew Asbury Rd. Pasadena, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Bayview Crematory 4/2/2010 Baltimore, MD Signature of Suneral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral 169 Riviera Dr. Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death s been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform certificate Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗌 No မ 4 Nursing Home 5 Residence 6 Other (Specify) this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending Accident Suicide 1 🗌 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who complete cause of death (Item 23a) (Type, Print) ONES, ME 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Tenry APR II 2010 : 56A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 21 STONE PINE COURT BALTIMORE BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1 X M 2 🗆 F Months Days 04/03/1945 217-40-9738 64 Yrs. **Director** MD Usual Residence of Decedent 28a-f shor 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD BALTIMORE BALTIMORE 1 Yes 2XX No Ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21 STONE PINE COURT 21208 <u>USA</u> 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 6 þ 1 Never Married 2 X Married ☐ Yes 2 X No 1 ☐ Yes 2 If Yes, Give 1 ☐ Yes 2 X No Specify: WHITE Specify: "natural", 3 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) OWNER CREDIT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MARCUS WEITZ RUTH FRANKEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra DONNA WEITZ/WIFE 21 STONE PINE COURT , BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY 04/07/2010 BALTIMORE, MD 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD PIKESVILLE. 23a. Part 1. Enter the disease, or complications that cause one death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ oncreate disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last -burial-Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 1 Yes 2 No ed by the a g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 sidence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director. / 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Attifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Numse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signaty fe and tit 53063 person who completed cause of death (Item 23a) (Type, Print) University

J. Eck Iman, M.D. Baltimer of Mary I and Gerarebour Caros Corres

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

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Records,

Division of Vital

32. Registrar's Signature

Amend 29c & 30 per DVR g902 4/8/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Joy 135AM Wood Vanda 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Regional Hospital aure1 P.G. aurel Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 215-90-1014 1 M 2 K Director MD 02/22/1962 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, If a Madical Evan item that be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince George Director Laurel 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7616 Stratfield LN 20707 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) US Elementary/Secondary (0-12) College (1-4or 5+) Consultant 12th 3vrs Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace Benjamin Ruth Wiley ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Wood/Husband 7616 Stratfield LN Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or concept 1 Burial 2 Cremation 3 Removal from State 4/16/10 Arbutus Mem PK Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Betts Funeral Home 21. Signature a Funda Service Licensee 1129 N. Caroline St. Balto., MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardiorespiratory disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ulmonary Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Morbid attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate 1 □ Yes 2 **X** No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To funeral To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D45928 Mondon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u> Andrew Stevens Nicholson, MD 7300 Van Dusen Road Laurel, MD 20707</u> 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar APR 0.8 201

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** R. Walker Geneva 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death **Examiner** N/A Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 1 □ M 2 🖫 F 213-26-9884 Director June28,1930 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, mendical Examination N/A MD Director Baltimore 1 MYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 516 Poplar Grove 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 3 ☐ No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12th Lexington Lady N/ASales Associate marked other ulth and Mental Hw 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sloan Gingles Beatrice Fair permit. Pages 1 and 2 sh.
Department of Health and
Important: If Item 27 is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Walker/Daughter 1103 Inner Cir. Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville VA 4/14/10 Crownsville, M 21. Signature 22. Name and Address of Facility Beverly D. Cromartie F/S of Funeral Service Licensee Amalle 2700 Edmondson Ave. Balto., MD 21223 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death ACUTE Immediate Cause (Final CEREBROVASCULAR **Physician** UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, learny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for selections of use as the burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISORDER Division of Vital Record 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy performe 1 ☐ Yes 2 🗆 No 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Lecritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES CURTOS 21229 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryiand		artment of F tificate of D		and IV	-	Glene Reg. No	201	Π	10	830
	Physicia	n/	1. Decedent's Name (First, Middle							2. Date of De	ath			3. Time	
	Medic Examin	al	4a. Facility Name (if not institution	EAGER n, give street and number)		-	4b. City, Town, or	Location	of Death	84	<u>වූ</u>	County of De		003	30 M
	Examin		Anne Arundel	Medical Cent	er	ı	Annapoli		Of Boatin			Anne Ar		del	
	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. las	**	If Under 1 Year Months Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da		9. B	Sirthpla Country	ace (State	o <i>r Foreig</i> n
	Director		180-28-1476 Usual Residence of Decedent		73	Yrs.				09/27/	1936	5		PA	
land	f shoved at	tor	10a. State 10b. County		10c. City,	Town or Loc	ation						10	d. Inside (City Limits
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vith th	23a o st be	eral [7437 Cherry	Tree Drive			10f. Zip Code 20759				10g. Ci US <i>I</i>	tizen of What 0 }	Countr	y?	
death	items er mu	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	/as Decedent of His Yes, specify Cubar	spanic Ori	igin? (Spec	cify Yes or No-	\neg	14. Race - Am			
036	Der artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2本外a 3 ☐ Widowed 4 ☐ Divorce	rried 1 X Yes 2 🗆	No		☐ Yes 2XXNo			iicari, etc.)		Black, Wh	,		
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בי וווי	al Hyg I othe vent,	Be	17. Father's Name (First, Middle,			Dares	Hallager	18. Moth	er's Name	(First, Middle,			ack	laru	
<u>≅</u> <u>ā</u>	Menta larked atic e	욘	Merle Edward	leager				Flor	ence	Mary N	elsc	on			
Mar 2 shou	th and 7 is m traum		19a. Informant's Name/Relations				g Address (Street a						Iip Co	de)	
a and	f Heal item 2 other		Olivia Scaggs 20a. Method of Disposition	Yeager/ Wife	20b. Pla	ce of Dispos	Cherry 1					20759 ocation - City o	or Tow	n. State	
Baitimore, Maryland 21215-0036 Dermit. Page 1 and 2 should be filed within 72 hours after	rtant o rtant: If ijury or		1XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify)		Hill	atory or other place Cemetery		April 201	LO	Laur	el, MD			
De le	Der al Impo any ir once	i v	21. Signature of Funeral Service	Licensee	M010		Name and Addres 3 Talbott						me,	P.A	•
				r complications that caused only one cause on each line.	the death.	Do not enter	r the mode of dying	g, such as	cardiac or	respiratory an	rest,		I II	Approxima nterval Be	etween
	ysician, Medical		Immediate Cause (Final disease or condition resulting in death)	aSTR	OKE								2	On t and	Death
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Physic	this c	유	1 Yes 2 No 27. Manner of Death	Hospital: 1 npatie	nt 2 EF	R/Outpatient 8b. Time of		_4 ∐ Nι				Other (Spe	cify)		
nding o	ath. r: After e funer	icate	1 Natural 5 Pendir 2 Accident Investi	ng (Month, Day,		injury	28c. Injury work? M 1 1	at Yes 2□	- 1	3d. Describe h	ow injury	occurred /			
IVISION OF	after des Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be		e, farm, stree	et, factory, office	-	2	8f. Location (S City or Tow		d Number or Ru	ural Ro	oute Numi	ber,
Hospita	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 \(\sum \) Medical E	Physician: To the best of n	amination a	nd/or investig	gation, in my opinior	n, death oc	ccurred at the	he time, date a	nd place,	and due to the	cause	e(s) and ma	anner stated.
To the	within To the compl		29b. Signature and title of certifier	Nurse Practioner: To the b	est of my ki	nowleage, as	29c, License	number	and place,		29d. Dat	119	7		
	+1		30. Name and address of person	Y. Krelige who completed cause of dea	eth (Item 23	(I) (Type, Pr.	U4	4	00		04	103/	10		
25	Α .		SUSAN H. K	RIEGERIN	is 4	1195	Defense	e Ar	dy ,	Annaf	oles	, Mis	214	101	
	State Registra	_	31. Date filed (Month, Day, Year)	32. Registra	s Signature	<u> 1.</u>	parker	,	/	/		,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rthur Berry Allar		1- For State	tate of Maryland		ment of H icate of D		Mental Hyg		201	0 10831
Physicia		Registrar 1. Decedent's Name (First, Midd	lle,Last)				2.	Date of Death		3. Time of Death
ledical Examir	ner	Arthur Berry						Month March 25, 2		2345 hrs
		4a. Facility Name (if not institution St. Mary's Hospital	on, give street and number	•)		City, Town, or Loc eonardtown	ation of Death		4c. County of De St. Mary's	ath
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last t				8. Date of Birth	(MM/DD/YYYY) 9.	Birthplace (State or eign
Director		215-62-7857	1XM 2F	56	Yrs.	Months Days	Hours Min.	10/31/	1953	Country)Maryland
á	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Location					10d. Inside City Limits
nd how a		Maryland St. M	Mary's	Crost	Mills					1 Yes 2 X No
Aaryland 28a-f show any 1 at once.		10e. Street and Number	ary s	Loreat		of. Zip Code		100	g. Citizen of What C	ountry?
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Deceden Armed Forces	?		ecedent of Hispan specify Cuban, Me			14. Race - An White, etc	nerican Indian, Black, :
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ours af	d b	15. Decedent's Education (Spe	or Dates:	mpleted) 16		Jsual Occupation of working life. DO			16b. Kind of Busine	
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-003 within giene. ther th	E O	12 17. Father's Name (First, Middle	e Last)	В	<u>uilding</u>	Inspect	O T Mother's Name (F		Construct	ion
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	Thomas Andrew					ry Edna		,	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		19a. Informant's Name/Relations				ldress (Street an	nd Number or Rur	al Route Numb	er, City or Town, St	
MD and 2 sho salth and 2 sho sa 27 is raumati		Beverly Randol 20a. Method of Disposition	.ph/Sister	20h Płac	25849 S	otterley	Cliffs	Lane,	Hollywood	MD 20636 or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	П	1 Burial 2 Cremation	n 3 Removal from Sf	tate crem	natory or other	place)		1		
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Department of the property of	1	Edward N. Brin	sfield. Jr.	M00052	12295	5 Hollyw	rood Road	1. Leon	ardtown.	MD 20650
Physician		23a. Part I. Enter the disease, or failure. List only one cause	r complications that caused	d the death. Do	not enter the n	node of dying, suc	ch as cardiac or re	espiratory arres	st, shock, or heart	Approximate Interval Between Onset and
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Box 68760, s death certificate be the attending physic of for use as the burind for use	W/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. It yes, outco	ome of pregnan	cy ₂ ∏ Fetalo		Ectopic pregnanc		23d. Date of deliver Month	very Day Year
ox 6 ath cer attendi	Physician/M			t time of death	5 Other	(Specify)				
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isior Attend er death. rector:	licati	2 Accident Inve	estigation 28e Place of I	njury - At home	, farm, street, fa	actory, office build				Rural Route Number, City
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To the within To the comp	Medical	29b. Signature and title of certific	and manner stated			29c. License nu			29d. Date signed (
	-	(m)).			O.C.M.E	Ξ.		March 26, 201	0
	ł	30. Name and address of person	n who completed cause of	death (Item 23a						
		Donna M. Vincenti, M			er 111 P	enn Street, Ba	altimore, MD	21201		
Sta Regist	:100	31. Date filed (Month DA) Deals		ar's Signature	1. Sou	as I				
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			 State Registrar Δm 	end#7	8 PorFH			0 -	tificate					Reg. N		LN	10832)
	Physicia	ın/	1. Decedent's Nam Christoph	e (First, Middi	adiran								2. Date of De Month March		² 2010	Year	3. Time of Death	4
	Medio Examir		4a. Facility Name (# Washingto	not institution	n, give street ar	nd number)			4b. City,	Town, o	r Location Par	of Death	March			of Death	13 : 33	Л
4	Funeral Director		5. Social Security N 579–11–55	umber	6. Sex 1 X M 2	7. A	ge (In yrs.	last birthday)	If Under Months		If Unde		8. Date of Bi	rth 19	50	Coun	lace (State or Foreig.	ın
	*		Usual Residence of	Decedent			,,,						04-01-	1 / 10		Nige:	ria	_
	Maryland 28a-f show otified at	irector	10a. State MD	10b. County	PG		10c. Ci	ity, Town or Lo	Hyat	tsv	ille					1	0d. Inside City Limits 1 Yes 2 □ N	
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3altimore, Maryland 21215-0036	d be filed Vental Hy arked oth	To Be	17. Father's Name (Lawrence		Last) K inwumi							ner's Name anah	e (First, Middle Ak		oyimu			
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P.O.	law requires that the nas been signed by the s 2 should be detach	y Pr	Part II. Other signif	icant conditi	ons contributin	g to death	but not re	sulting in the u	nderlying c	ause giv	ven in Part	1.	23e. Did	tobacco	use conti	ribute to th	e cause of death?	
rds,	equires een sig ould b	ted											1 🗆	Yes 2	2 🗆 No	3 🗌 Prof	oably 4 X Unknow	'n
ecol	e law re has by ge 2 sh	Completed	-										24a. Was auto perf	DSV	- 1	Were autor prior to co death?	osy findings available npletion of cause of	÷
al R	an: Th tificate tor, pa	Be Co	25. Was case referre	ed to medical				<u></u>		26. Pl	ace of Dea	ath (Check		ormed? 2.2.1	No	1 🗌 Yes	2 No	
Vit.	hysici his cer ıl direc	요		No	Hospital:			ER/Outpatier	t 3 🗆 DC	Othe	er: 4 □ N	lursing Ho	me 5 🗆 Resi	dence	6 🗆 Othe	er (Specify		
Division of Vital Records,	Attending Physician: The r death. sctor: After this certificate by the funeral director, page	Certificate:	27. Manner of Death 1. Natural 2 Accident	5 Pendi	ng gation	Date of inj (Month, Da	ury ay, Year)	28b. Time of injury	M 28	Bc. Injury work 1 🗆			28d. Describe	how inju	iry occurre	ed		
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	I Certi	3 Suicide 4 Homicide	6 ∐ Could detern		Place of In building, et		ome, farm, stre iy)	et, factory,	, office			28f. Location (City or To			er or Rural	Route Number,	
	ne Hospit in 24 hour ne Funera pleted fill	Medical	(Check 2	Medical	Physician: To Examiner: On to Nurse Praction	he basis of	examinatio	on and/or invest	igation, in n	ny opinio	on, death o	ccurred at	the time, date	and plac	e, and due	e to the car	se(s) and manner stat	ted.
	To the Within Com	_	29b. Signature and	title of certifie	1	-de	14	- HD		_	number	20		29d. D	ate signed	d (Month, I	Day, Year)	
			30. Name and addre	ess of person	who completed	d cause of	death (Iten	n 23a) (Type, P	rint)		-		,		12	1110		
14			Dr.	Padma_	Chiruma	milla	76	00 Carı	oll P	we.	Tako	oma P	ark, MI	20 ر	912			_
	Stat Registra		31. Date filed (Monta MAR 2. 6	2010	Denna	32. Regis	rar's Signa											

234 P.G-IM ME

Please Type or Print in Black Indelible Ink / Finsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year 1:20 P Wanda Iris Blake March 26, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 7082 Quick Tree Farm Ct. Examiner 4b. City, Town, or Location of Death 4c. County of Death Hughesville Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 9 -12 -1957 Social Security Number 7. Age (In vrs. last birthday) **Funeral** 5. Social Security Number 217-78-1301 9. Birthplace (State or Foreign 1 ☐ M 2 ☐XF Months 52 Washington, DC Director Usual Residence of Decedent 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits 28a-f show Ħ event, the Medical Exeminer must be notified Maryland Charles 1 □Yes 2 □No Marbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 4175 Chicamuxen Road 20658 United States Funeral or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: American Indian þ Specify: 3 Widowed 42 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George O. Gray, Sr. ဂ Elizabeth E. Proctor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Schirra J. Gray, Sr./Brother permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. 6326 Hard Bargain Circle, Indian Head, MD 20640 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brinsfield-Echols Crem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State March 31 4 □ Donation 5 ☐Other (Specify) 2010 Charlotte Hall, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se's consequence of) Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) Division of Vital Records, P.O. s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has briege to see the country of the co 24a. Was an autopsy performed? 2 🗆 No 1 □Yes 2 □No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Mother (Specify) Hospital: Other: 4 Nursing Home 5 Residence 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation spital or Attendi nours after death. neral Director; A / filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 C Homicide within 24 hours To the Funeral Legertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 30 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physici /Medic Examir

Funeral Director

1 _ State	State of Maryland / Dep	partment of F ertificate of			ene . No. 20		1083
Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death	. 110. 113	, , ,	3. Time of Death
	BUZOLICH			MAR 17	2010	Year	4:06 P N
4a. Facility Name (If not institution, give stre		4b. City, Town, o	r Location of Deat	h	4c. County	of Death	
NATIONAL NAVAL MED		В	ETHESDA		MO	NTGOM	ſERY
Social Security Number 6. Sex	7. Age (In yrs. last birthda	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	(ear)	9. Birthp Coun	lace (State or Foreig
237-29-6418	^{1 2⊠ F} 51 Yrs.	Wionins Days	Tiours Will.	Oct. 5,	1958	Germa	
Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				11	0d. Inside City Limit
							1.23Yes 2.□N
D.C. District on 10e. Street and Number	f Columbia W	ashington 10f. Zip Code		100	. Citizen of \	What Coun	try?
305 C Street #202 1	NT E	20002			ermany		.,,.
			lispanic Origin? (5			e - Americ	an Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	3. Was Decedent of H If Yes, specify Cub 1 □ Yes 2√□ No	an, Mexican, Puer Specify:	to Rican, etc.)	Blad	ck, White, e y.White	etc.
15. Decedent's Educal (Specify only highest grade c	tion 16a. De (Gi	cedent's Usual Occupive kind of work done	during most of wo		b. Kind of B	usiness/Ind	dustry
Elementary/Secondary (0-12)	College (1-4or 5+)	ager of Fa	*	3 B	anking	7	
17. Father's Name (First, Middle, Last)	2 11011	ager or re		me (First, Middle, Ma			
Rudolf Feulner			Marga Di	rescher			
19a. Informant's Name/Relationship (Type Mark D. Buzolich		ailing Address (Street					
20a. Method of Disposition	20b. Place of Dis	sposition (Name of	1		c. Location		
1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)		rematory or other place to oln Crema	atory 3/			od,Ma	ryland
21. Signature of Funeral Service Licensee	M01463	22. Name and Address 1040 Rocks		Simple Tri ke, Rockvi		aryla	nd 20852
23a. Part 1. Ent -r he dis/as-i, or complica shock, or he rt fail re. List only one Immediate Caus/ (Fina	tions that caused the death. Do not cause on each line.	enter the mode of dyi	ng, such as cardia	ac or respiratory arres	t,		Approximate Interval Between Onset and Death
disease or condition resulting in death)	METASTATIC LUN Due to (or as a consequence of):	G CANCER				-	
Sequentially list conditions, if any leading to immediate	Due to (or as a consequence of):					_	
cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence or).						
that initiated events c resulting in death) Last	Due to (or as a consequence of):	,					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions control							
IF FEMALE:	Maria automa of prosporti						
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ey .			ate of delive onth	ery Day Year
Part II. Other significant conditions contri	ibuting to death but not resulting in the	e underlying cause giv	en in Part I.	23e. Did toba	cco use con	tribute to the	ne cause of death?
	, , , , , , , , , , , , , , , , , , ,			1 ☐ Yes	2 ∑ No	3 ☐ Prot	oably 4 🗆 Unknow
				24a, Was an	24h	More oute	nov findings availab
III				autopsy performe	ed?	death?	psy findings availab mpletion of cause of
				1. ☐ Yes 2	□No	1 ☐ Yes	2 🖾 No
25. Was case referred to medical examiner?	spital:	Oth	or:	eath (Check only one)			
1 ☐ Yes 2 ☐ No	28a. Date of Injury 28b. Time		+ C3 14d15illig	Home 5 Residen			(y)
1 Natural 5 Pending	(Month, Day, Year) Injur	y Wo	ḱ? lYes 2 □ No	200. 20001120 11011	,,		
3 ☐ Suicide 6 ☐ Could not be	28e Place of Injury - At home, farm.			28f. Location (Stre	et and Num	ber or Rum	al Route Number.
4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	,,		City or Town,			,
29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my knowledge, decr: On the basis of examination and/o and manner stated.	eath occurred at the t r investigation, in my	ime, date and plac opinion, death occ	ce, and due to the ca curred at the time, dat	use(s) and make and place	nanner as s , and due to	stated. o the cause(s)
29b. Signature and title of certifier	A. a marmor stated.	29c. Licen:	se number	29	d. Date signe	ed (Month,	Day, Year)
Mult 2 12	ms ms	0101	231334 (VA)	MARCH	22.	2010
30. Name and address of person who com		pe, Print)		NAL NAVAL			NTER
ROBERT F. BROWNIN	An Desistanda Cianatura		BETHE	SDA MD 208	889-56	UU	
31. Date filed (Moeth, Day, Year) ARR 25 2010	32. Registrar's Signature	will.					
2010	peners p. you	4			··		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2010 Physician/ Month APRIL Blacker Judv M 14:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS - REGIONAL MEDICAL CENTER CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) . Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 □ **√** Months Days Hours Min. Dec 24 ^{ar)}1944 Director 214-42-0540 65 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10d. Inside City Limits 10c, City, Town or Location filed within 72 hours after death with the Maryland Director MD Allegany Cumberland 1 ☐XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 107 N. Johnson Street Apt. 1 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify. 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) / Hygiene. • **∼ther than "** Elementary/Seconday (0-12) College (1-4 or 5+) custodian Allegany Board of Ed Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edgar Hersh Hazel (Lowery) Hersh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 107 East Elder Street Cumberland MD 21502 Judithan Blacker daughte permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Hillcrest Memorial Park 4/6/2010 Cumberland MD 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Li 22. Name and Competition Pull Veral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 mont Day Month Year Pregnant at time of death signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown ↑ ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? After this certificate 1 Yes 2 No 2 Yes 25. Was case referred to ical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending eral Director: A 1 🗀 Yes 2 No Accident Investigation Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29c. License number D50844 on who completed cause of death (Item 23a) (Type, Print) 30. Name and address LOVERIA JOSE T., MD, 912 SETON DRIVE, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State R UB Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # 10c&19b Per FH G902 4/14/2010 JH State of Maryland / Department of Health and Mental Hygiene 0836 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2010 Physician/ Month Patrick Steven Carlucci March 24 Medical 8:44 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8362 Grovenor Ct. White Plains Charles 5. Social Security Number **Funeral** Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington, D(8. Date of Birth 5ex 1 ፟ M 2 ☐ F (Month, Day, Yea -28-1966 Months Days Hours Min. Director 212-62-0813 43 DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 🗌 Yes 2 🗓 No Maryland Charles Walderf White Plains 5 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral items 23a 8362 Grovenor Ct. 20695 United States death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 5 Black, White, etc. 2 1 Never Married 2 M Married 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", White 3 Widowed 4 Divorced Specify: Completed Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Artist Comic Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be John J. Carlucci other traumatic Jo Ann Cobb 19a. Informant's Name/Relationship (Type, Print) 896/2iling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Carlucci/Wife 342 Grovenor Ct., White Plains, MD 20695 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) ö March 29, Charlotte Hall, MD Brinsfield-Echols Crem. any injury permit. 21. Sig atyre Funeral 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ OF disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year ☐ Pregnam ☐ Unknown 2 No the detached 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Priknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? After this certificate 2 🗌 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 1 Yes 2 No after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 3 🗌 only one) 29b. Signature and title of certifier 29c. License numbe 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) NAR 29 legistrar's Signature State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician March 28, Day 2010 DIINN 8:52 P.M Dorothe Marie /Medical 4b. City, Town, or Location of Death Hagerstown 4c. County of Death Washington 4a. Facility Name (If not institution, give street and number) **Examiner** 941 West Irvin Avenue 8. Date of Birth (Month, Day, July 23, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1923 Months Days Hours 1 □ M 2 🕅 F Min. 189-12-6333 86 Pennsylvania Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits show "natural", or items 23a or 28a-f shov official Examination must be notified at Director Maryland Washington Hagerstown YE Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 941 West Irvin Avenue 21742 U.S.A. Pages 1 and 2 should be filed within 72 hours after death varent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23, ury or other traumatic event, the leadiest Exertial manus Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 🛮 Married 1 ∐Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) managed classified advertising newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Joseph Cherry Edna McCloskey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Bleesz - daughter 1016 Lindsay Lane, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or of 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hagerstown Crematory March 29 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Lalut 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RITICAL YEARS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year signed by the a 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? certificate has OGRENIS LOME ATRIAL 1 TYES NITO 1 ☐Yes 2 ☐No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

SH-10

State Regist<u>rar</u>

DHMH 17 Rev 1/2001

MAR 3 0 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 **Physician** March Mary Ellen Dimitrov 10:02 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number)2 Examiner Washington 2014 Windsong Drive Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2XXF Months Days Hours Min. 219-56-4561 57 Maryland Director July 13, 1952 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d Inside City Limits 10a. State 10b. County ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Wedgal Expertment must be notified at 1 □Yes XXNo Completed by Funeral Director Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt.D 21740 USA 2014 Windsong Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Joseph Waters Audrey Mae Falter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Heatth a Important: If item 27 is any Injury or other trains once. Hagerstown, MD 21740 2014 Windsong Drive Apt.2D Roumen N. Dimitrov - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Other (Specify) Smithsburg Crematory 03-26-2010 Smithsburg, Maryland 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Funeral Service, License 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the dicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 \sum Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0026579 30. Name and address of person who comp

Registrar DHMH 17 Rev 1/2001

State

Kuglar

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

nedical Compus Road,

ted cause of death (Item 23a) (Type, Print)

107 Registrar's Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** David William Goldstein March 22, 2010 7:25 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Lorien Taneytown Nursing Center Taneytown Carroll 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 XM 2 1 F Director 579-16-2370 89 Nov 5, 1920 New York Usual Residence of Decedent 10h County 10c. City, Town or Location 10a State show 10d Inside City Limits death with the Marylar the Medical Examiner must be notified at Director 1 1 Yes 2 □ No 28a-f Carroll MD Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 801 Horseshoe Lane 21787 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Types 2 No 1943or items, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. after 1 ☐ Never Married 2 ☐ Married Yes 2 Yes, Give Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify 2 72 hours 3 Widowed 4 Divorced Year or Dates 1945 'natural", White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ulth and Mental Hygier

27 Is marked other the traumatic event, the 12 Salesman Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Goldstein Freida Kimmel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 801 Horseshoe Lane Taneytown, Maryland 21787 Paula Rein/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem Grds. 3/25/2010 | Falls Church, Virginia 22. Name and Address Danizansky-Goldberg Memorial Chapels 21. Signature of Funeral Service License Melissa Greenhut Meli Stlance M01597 1170 Rockville PIke Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Large Cell Lymphoma Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): executed Examir burial-trar Due to (or as a consequence of): Box 68760. attending physician law requires that the death certificate be Physician/Medical as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No P.O. ed by the 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Chronic Obstructive Pulmonary Disease page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Carcinoma of the Lung autopsy perform The certificate 1 ☐Yes 2 X No 1 ☐ Yes 2 🖾 No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: Pompletely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within ? 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 H55845 March 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Kevin J. Brewster,

Day, Year)

MD

32 Registrar's Signat

ack

One Kings Drive, Taneytown, Maryland 21787

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20, Day 2010 Year Mary 6:30A. Gertrude Garner Medical 4a. Facility Name (if not institution, give street and number) tb. City, Town, o Adelphi ^{4c. County of Death} Prince George's Examiner Hillhaven Assisted Lvg. Nursing & Rehab Center . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🂢 F Min. 577-64-8066 Hours May 4, 1916 93 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Adelphi 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3210 Powder Mill Road 20783 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 1-4 Travel Bureau Coordinator Canada Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 (unk) (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13111 Taney Drive Beltsville, Maryland 20705 Virginia M. Horton -niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Buriai 2 Ϊ X remation 3 🗆 Removal from State Metropolitan Crematory 3/24/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Bonald Adress Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and-trans that initiated events Due to (or as a consequence of) resulting in death) Last the burial attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the g 🗌 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Asthma; Gastroesophageal Reflux Disease; Failure to 2 XNo 3 Probably 4 Unknown 1 Yes page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Thrive has autopsy performed? Yes 2 XNo 1 ☐ Yes 2X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one

State Registrar 29b. Signature and title of

31. Date filed (Month, Day, Year) MAR 25 2010

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Edward Maslen, M.D. 7525 Greenway Center Drive,#312 Greenbelt, Md

29c. License number

D55559

29d. Date signed (Month, Day, Year)

March 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23^{Day} 2010^{ear} MARCH **GRAY** 8:02 P M DORIS E. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGE'S UPPER MARLBORO 9101 UTICA PLACE 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Davs Hours Min 1 M 2 X F Director MARYLAND 216-30-4156 ĴAN Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S UPPER MARLBORO 1X Yes 2 No 10g. Citizen of What Country? USA 10e Street and Number 10f Zin Code Hygiene. other than "natural", or items 23a or vent, the Medical Examiner must be r Funeral 20774 9101 UTICA PLACE filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) nit. Page 1 and 2 should be filed with autment of Health and Mental Hygien ortant: If item 27 is marked other injury or other traumatic event, the 12TH HOUSE KEEPER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FLORENCE SNOWDEN HENRY D. HERBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE GRAY/HUSBAND 9101 UTICA PLACE UPPER MARLBORO, MARYLAND 20774 . Method of Disposition 1♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date cemetery, crematory or other place, LAUREL, MARYLAND 4 Donation 5 Other (Specify) MD NATIONAL CEMETERY 3/30/10 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME ₫ 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ METASTATIC BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Sequentially list continuous, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician for use as the burla Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛂 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Director: After this certificate 2₹□ No 1 Tes Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death ë 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Certificat death. 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

only one) 29b. Signature and title of ca

31. Date filed (Month, Day, Yes

MAR 2 8 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registry 's Sigr

CHITRA VENKATRAMAN M.D.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

7300 HANOVER DRIVE # 301 GREENBELT, MARYLAND

29d. Date signed (Month, Day, Year)

MARCH 24, 2010

20770

29c. License number

D41715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2010 ALFRED F. HENCKEL, SR. March 20 12:39 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Pines Talbot Easton Genesis HealthCare -If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 X M 2 □ F Months 84 220-26-2082 Director PENNSYLVANIA 06/13/1925 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the thoulest Evan it we make the motified at Director 1 ☐Yes 2 K No ST. MICHAELS MARYLAND TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21663 UNITED STATES 8579 UNIONVILLE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ▼Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No 1 ☐ Yes 2 📉 No Specify: Specify: WHITE <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION 12 DRIVER permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygid Important: If item 27 is marked other 1 any Injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERTHA UNKNOWN FREDERICK J. HENCKEL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8579 UNIONVILLE RD., ST. MICHAELS, MD 21663 MARJORIE HENCKEL/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION 03/22/2010 STEVENSVILLE, MD 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Lie 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA WANTER **Physician** RECTAL /Medical Due to (or as a consequence of): Examiner ALUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examine certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 Other (specify) P.0. the 9 I Inknown 9 Unknown ģ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Uknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas certificate 2 1 □Yes 1 TYes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 (SP) Other: 4 Sansing Home 5 Residence 6 Other (Specify) 2 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the hin 24 hours after death the Funeral Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier CPN 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

725-6

State Registrar

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DHMH 17 Rev 1/2001

UTCHMAN5

610

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RNP

REESIDI

31. Date filed (Month, Day, Year)

MAR 22 2010

		I-For State Registrar	-	Ċ	ertifica	te of	Death		,	ا	Reg. No.	0 1	0 1004
Physician	1/	1. Decedent's Name (First, Midd	lie,Last)			-			2	2. Date of De Month	ath	ear	3. Time of Death
Medical Examin	er	Geoffrey Paul								March 28	3, 2010		1129 hrs
		4a. Facility Name (if not institution 16960 Bay Creek Lan		number)		41	o. City, Town, or L Dameron	ocation o	of Death		4c. Count St. Ma		1
Funeral Director		5. Social Security Number 215-84-5177	6. Sex	7. Age (In yrs	, last birtho	lay) Yrs.	If Under 1 Year Months Days	If Unde Hours		8. Date of B 8-15-	irth(MM/DD/YY) 1963	Foreig	thplace (State or onVietnam untry)
Α.		Usual Residence of Decedent		I do no									
and f show any nece.	اة اة		Mary's		y, Town or echan								10d, Inside City Limits 1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 27115 Erin Driv	ve	_			10f. Zip Code 2065	9			10g. Citizen of V United		*
ath with tems 23	Funeral	11. Marital Status 1 Never Married 2 X M		ecedent Ever in Forces?	U.S. 1		Decedent of Hisp s, specify Cuban,					ce - Ameri ite, etc.	ican Indian, Black,
after de	Dy Fu	3 Widowed 4 Div	orced If Yes, Give York	ear		1 🔲 😯	res 2 No	specify:			Specify	. Wh:	ite
hours naturi	8	15. Decedent's Education (Spe-	cify only highest gr				s Usual Occupationst of working life, [16b. Kind of E	Business/I	Industry
MD 21215-0036 d 2 should be filed within 72 th and Mental Hygiene n 27 is marked other than " numatic event, the Medical.	Completed	Elementary/Secondary (0-12)	2	(1-4 or 5+)	1	ilde					Home	5	
15-C	a. I	17. Father's Name (First, Middle,	, Last)				1				Maiden Surnam	ie)	
212 212 212 Menti be mark		George Havens 19a. Informant's Name/Relations	ship (Type, Print)		19b. I	Mailing /	Address (Street		Power or Rui		mber, City or To	wn, State	, Zip Code)
MD d 2 sho th and fth and n 27 is	L	Melissa L. Have	ens/Wife				Erin Dr		Mecl	nanics	ville,	MD 20	0659
Baltimore, bernit. Pages I an Department of Hea Important: If iten njury or other tra	1	20a. Method of Disposition 1 Burial 2 A Cremation 4 C Population 5 Other Se	n 3 Removal	from State	Place of I	Dispositi	on (Name of ceme or place)	etery,	ΑŢ	Date Oril l	20c. Location	- City or	Town, State
timent rtant:	_ L	4 Donation 5 Other Sp 21, Signature of Funeral Service	becny.	BI	THELL				-	2010			Hall, MD
Ba Permi Depa Impo	+	7. h 7.h.	Licensee	M0081	7								H., P.A., 11, MD 20622
Physician	+	23a. Part I Enter the disease, or failure. List only one cause	complications that										Approximate Interval
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Bronch										Between Onset and Death
		Sequentially list conditions,	b	a consequence							,		
	51	if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated	C	a consequence	100								
ecuted and ransit	<u> ב</u>	events resulting in death) Last	Due to (or as	a consequence	of):								
e be exectly sician a burial - 1	Medical	UNPENDED	AMENDED	23a,27,r	erm.I	Ξ 29	02 4/30/	10 T	T				
876(rtificate ing phy		F FEMALE: 3b. Was decedent pregnant in th past 12 months?	23c. If yes	, outcome of pre	gnancy 2	_			pregnanc	у	23d. Date of Month		ay Year
Box 68760, death certificate by the attending physic d for use as the bur	Frigsician		4 Preg	nant at time of d	leath 5	Othe	r (Specify)						
P.O. B es that the digned by the detached th		Part II. Other significant conditi			resulting in	the und	derlying cause giv	en in Par	rt I.	23e. Did t	obacco use con	ribute to	the cause of death?
S, D	a n												ably 4 🗸 Unknown
of Vital Records, ng Physician: The law require After this certificate has been sineral director, page 2 should be a considered.	pajaidijion									24a. Was auto			topsy findings available ompletion of cause of
tal Rec		25. Was case referred to medical					00 Pi	f December 1	01	1 Yes		1 🗸 Ye	s 2 No
Vital hysician: hysician: this certif	ם ב	examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outp	atient	26.Place of	thor re-	Nursing I		Residence 6	✓ Other	Scene
C fi _ ~ 4 6	-	27. Manner of Death 1 X Natural 5 Pend	(Mont	e of Injury h, Day,Year)	28b. Tim	ne of Inju	ury 28c. Injury	_		3d. Describe	how injury occu	red	
Division of Supplied to Attending Photors after death. Ineral Director: After I filled in by the funeral	Cel unication.	3 Suicide 6 Could	stigation 28e. Pla d not be mined (Specify		nome, farm	, street,	factory, office buil	lding, etc	. 28	Bf. Location (or Town, \$		per or Rui	ral Route Number, City
8 E B > 1		4 Homicide	nysician: To the be	st of my knowled									
To the Ho within 24 To the For completed		29b. Signature and title of certifier	and manner		and/or inve	saligation	29c. License r		uned at ti	ie time, date			oth, Day, Year)
		Fanal Dough	all nu	1			O.C.M.				March 29,		,,,,,
	3	80. Name and address of person Pamela E. Southall, M		se of death (Iter	,	111	Penn Street,	Baltimo	ore. MD	21201			
Stat	e (1. Date filed (Month, Day, Year)		egistrar's Signat									
Registra	ir	APR 0 5 20	010 Dens	A.	do	M							
DHMH 17 Rev 1/200 OCME 2006	1		120.00	,	ORIG	INAL					OGN	ΙE	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23art1,25 per me 2902,04/05 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month March 2010 Maurine Holbert Hogaboom 1:55 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Hermitage @ St. Johns Creek Calvert Solomons 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 - M 2 1 F Months Days Hours Yrs. Director 452-03-3210 Texas Usual Residence of Decedent 10b. County 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20688 13325 Dowell Road United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry retal Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Theater permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important. If item 27 is marked other 1 any injury or other traumatic event, the Actress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Holbert Ada Viola Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Julia Bates</u> / Power of Attorney P.O. Box 244 St. Mary's City, Maryland 20686 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XI Cremation 3 Removal from State Brinsfield-Echols Cre 03/31/2010 | Charlotte Hall, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Tatracerebral Frysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER -transit The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Box 68760 attending physical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed' 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) 2/25/NO Hospital 1 X Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director After leted filled in by the fun Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 147610 30 50)0

DHMH 17 Rev 7/2009

State Registrar

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#

Prince Frederick, Md

Hospital Road

32 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110

J Tardio

David

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 28^{Day} 2010^{Year} **Physician** 2:05 P M Ruby L. Hammond /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Ravenwood Assisted Living Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 28, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Maryland 215-26-1817 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Expraiser traist be realled at 1 □Yes 24 No Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 Luxor Lane 21740 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify Specify: 2 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bruce Howard Ella Indiana ည Snyder Beckley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tratence. Patsy A. Ardinger - Daughter 18515 Kent Ave. Hagerstown, Maryland 21740 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Apr.1,2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery Osborne AdPunerally Home, P.A. 425 S. Conococheaque St. Williamsport, MD 21795 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Concentive Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed signed by the attending physician and it be detached for use as the burlal-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
□ Live birth 2 □ Fetal death
□ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Records, ۾ 2000 icate has been si page 2 should b 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐Yes 2 🕱 No Division of Vital 9 Hospital or Attending Physician: 7 24 hours a er death. Funeral Director Affer this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Ceath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3-29-10 D0063233 30. Name and address of a rson who completed cause of death (Item 23a) (Ty., Print) 3H-5 Northern Ave Hogerstown MD 21742 Shahid Mahmood 580 gistrar's Signature Yea 3 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	f Marylan	-	rtment of H		Mental Hyg	iene 2	010 108	46
f	Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of Deat	- Day - 2010	Year 3. Time of Death 3:00 P	
	/Medio		HELEN HARPER 4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, or	Location of Dea		4c. County		
-			Clinton Nurs				Clinton If Under 1 Year	1 If Under 24 Hr	C 10 D 1 (B) #	Prin	ce George's	
	Funeral Director		5. Social Security Number 158-20-8694	5. Sex 1 □ M 2 □ XF	7. Age (In yrs. In 79	ast birthday) (Yrs.	Months Days	Hours Mir		1°9°30	9. Birthplace (State or Forei Country) NJ	gn
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limi	ts
	e Mary la-f sh	ctor	Maryland Prin	ce Geor	ge s	Suit	land				1∭Yes 2□N	10
	with the	Directo	10e. Street and Number			-	10f. Zip Code				What Country?	
	ms 23	Funeral	4656 Lacy Ave	12. Was Dece	dent Ever in U.S	3. 13. V	20746 Vas Decedent of Hi	spanic Origin? (Specify Yes or No- rto Rican, etc.)	USA 14. Rad	ce - American Indian,	
36	2 should be filed within 72 hours after death with the Maryland and Memted the Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, trai fection Exw. Irvi. must be notified at	by Fui	1 ☐ Never Married 2 ☐ Marrie	If Yes, Giv	2 ∑ No ∕e		fYes, specify Cuba □Yes 2 X □No	n, Mexican, Pue Specify:	rto Rican, etc.)		ck, White, etc. y: $B1$ ac k	
00-6	2 hours atural'		3 ☐ Widowed 4 💢 Divorced	Year or Da	ates:	16a. Deced	lent's Usual Occupa	ation			usiness/Industry	
121	vithin 7.	Completed	(Specify only highest	College (1	-4or 5+)		kind of work done o DO NOT use retired es Clerl			Drive	te Industry	
7 0	filed v If Hygie other i	a	12th 17. Father's Name (First, Middle, La	ast)		Sal	es cren		ame (First, Middle, N			
ylar	ould be Menta larked laffc ev	To B	Arthur Davis						e Wright			
Mar	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationshi Janice E. Har		ghter	1	•		Rural Route Number, ${\sf uit1and.}$		State, Zip Code) 1and 20746	
ore,	es 1 ar of Hea fitem : r other		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3		20b. PI		sition (Name of natory or other place				City or Town, State	
Baltimore, Maryland 21215-0036	it. Pag rtment rtant: I njury o		4 □ Donation 5 □ Other (Spe	ecify)		erdal		tory 03	3-26-10	River	dale, MD	
g	permit. Pages 1 and 2 should be Department of Health and Mentic Important: If item 27 is marked any injury or other traumatic en once.		21. Signature of Funeral Service Li		10/37	4 .			4111 PA	Ave.,	20746 Suitland, MI ——	
4	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final	nly one cause on e	ach line.	. Do not ente	er the mode of dyin	g, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Deme	or as a consequ	ence of):						
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8/60,	certificate be executed rding physician and ise as the burial-transit	cal E	resulting in death) Last	Due to (or as a consequ	ence of):						
20	artificate ing phys as the	Medic	IF FEMALE:	u.								
POX P	attendi for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	come of pregnal pirth 2 Fetal nant at time of de	death 3	Ectopic pregnancy Other (specify)	,			te of delivery onth Day Year	23
л. Э.	at the d by the	hysi	1 □ Yes 2 □ MaNo 9 □ Unknown	9 □ Unkn	own							
Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	by	Part II. Other significant condition	s contributing to de	eath but not resu	Iting in the un	derlying cause give	en in Part I.			tribute to the cause of death? 3 Probably 4 Unknow	vn
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Įa Įa	an: Th tifficate or, pag	a	25. Was case referred to medical					26 Place of De	perform 1 □ Yes 2 eath (Check only one	2 🖾 No	death? 1 □ Yes 2 □ No	-
2 2	hysici his cer Il direct	To B	examiner? 1 ☐ Yes 2 ሺ No	Hospital: 1 ☐ I	npatient 2 1	<u>.</u>	t 3 DOA Othe	er: 4 🖾 Nursing	Home 5 ☐ Reside		ner (Specify)	
00	ding P. h. After I funera	tion:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investiga		of Injury h, Day, Year)	28b. Time of Injury	28c. Injury Work	rat ? ∕es 2 ⊟No	28d. Describe ho			
IVISION	or Atter fter deat Sirector. in by the	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place	of Injury - At hor ng, etc. <i>(Specify</i>	me, farm, stre	eet, factory, office		28f. Location (St. City or Town	reet and Numb , State)	per or Rural Route Number,	
_	Dspital of hours a uneral E		29a. Certifier 1 X Certifying	Physician: To the	best of my know	vledge, death	occurred at the tin	ne, date and pla	ce, and due to the c	ause(s) and m	anner as stated.	-71
	the Ho	Medical	(Check only one) 2 Medical E. 29b. Signature and title of certifier	and manr	asis of examinat ner stated.	ion and/or inv	29c. License				and due to the cause(s) d (Month, Day, Year)	_
	5 14 5		> William	1 Can	_		D352		2	_	h 23, 2010	
	2			anner,	MD 11	701 L	Print) ivingst	on Rd.	,Ft. Was	hingt	on, MD 2074	4
	Star Registra		31. Date filed (Month, Day, Year) MAR 2 8 2010	Serve)	egistrar's Signat	ure						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per PHY G902 4/15/2010 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) **Billie Fletcher** Heinrich 2. Date of Death Physician/ Month Year Day Heinrich **Billie** HIH: Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death Examiner 4c. County of Death Allegany 209 Allendale Avenue LaVale 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** Months Days Hours Min Dec 12 ^{ar)}19<u>33</u> 218-30-0056 Yrs 76 Director Usual Residence of Decedent or 28a-f shov 10a, State 10b. Count 10c. City, Town or Location within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Allegany LaVale 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 209 Allendale Avenue 21502 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Divorced Specify. white 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important if frem 27 is marked other than any injury or other traumain. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) laborer Celanese Textile Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Fletcher Ethyl (Dawson) Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
209 Allendale Avenue LaVale MD 21502 Richard Heinrich husband 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rocky Gap Veterans Cemetery 4/5/2010 MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign here of Funeral Service 22. Name and Address of Full Fruit Frail Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Month been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 sl autopsy certificate 1 Yes 2 No Yes 2 4 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 -Natural 5 Pending injury 1 Yes 2 🗀 No ☐ Accident ☐ Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d Date signed (Month Day Year) 2010 0017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) La Vile J730117 31. Date filed (Mo State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 5:45 PM Hensell David John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland 609 St. Mary's Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months Hours Min Jun 24, ^(ear)19<u>24</u> **Director** 85 219-14-6626 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 609 St. Mary's Street 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates WW II Specify: Completed 3 Divorced 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) manager Kelly Springfield Tire Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ John Milton Hensell Mary Ocie (Romans) Hensell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 609 St. Mary's Street Cumberland MD 21502 wife 609 St. Mary's Street Bette Hensell 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Memation 3 Removal from State Scarpelli Funeral Home, P.A. 4/3/2010 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address III Fulleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Page 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest effects, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CADDIOGULMENTER Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit fo the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 No Accident Investigation Suicide 3 Suicide
4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signaty

and title

JAMS

DHMH 17 Rev 7/2009

625 KENT AVEN

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of M		artment of Health and N rtificate of Death		giene	10849
			Registrar 1. Decedent's Name	(First, Middle, Last,)		unoute of Douit	2. Date of Dea	ath	3. Time of Death
	Physicia		LUTH	MATILI	IN KEN	DLE		Month 3	Day Year 201	
	/Medic Examin		4a. Fecility Name (If		• • • • • • • • • • • • • • • • • • • •		4b. City, Town, or Location of Death	1	4c. County of De	ath
			Coffman	Nursing			Hagerstown			shington
	Funeral Director		5. Social Security Nu 182–22–555	51 10	7. A	ge (In yrs. last birthday) 91 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da)	h y, Year) 9. B 1918	rthplace (State or Foreign Country) Maryland
	yland how		Usual Residence of I	Decedent 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits 1 ☐ Yes 2X No
	e Mar	ctor	Maryland	Washin	gton	Wi	lliamsport			
	ith th	Dire	10e. Street and Num				10f. Zip Code		10g. Citizen of What (
	ath w	ral		ohn Marti		S	21795	pecify Ves or No.	14 Bace - An	OA nerican Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. bd other than "naturel", or Items 23a or 28a-f show event, the Medical Evarult at must be motified at	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Was Decedent Armed Forces 1 Tes 2 If Yes, Give Year or Dates:	No	Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puert 1 ☐ Yes XX No Specify:	o Rican, etc.)	Black, Wh	
21215-0036	2 hou	ted	(0	15. Decedent's Edu	ication	16a. Dece	dent's Usual Occupation	tking	16b. Kind of Busines	s/Industry
215	- 100	Completed	(Specification (Speci	fy only highest grad dary (0-12)	College (1-4or	5+)	kind of work done during most of wor DO NOT use retired)	King		
21	filed wit Hygien ther tha	Son	12		3		istered Nurse		Govern	nment
Maryland	should be filed withir of Mental Hygiene. marked other than matic event, the Ma	Be	17. Father's Name (F						Maiden Sumame)	
Z	should be nd Mental marked o umatic eve	ပ္		Marshall	Moore	105 Maili	Lillie ng Address (Street and Number or Ru		Mills	Zin Code)
a	12 sho h and 7 is mu treumu		19a. Informant's Nar Cheryl Wi				3 John Martin Dri			
	is 1 and 2 should of Health and Men item 27 is marke other treumatic		20a. Method of Dispo		augneer		osition (Name of matory or other place)	Date	20c. Location - City	
Baltimore,	0 0			Cremation 3 □I 5 □ Other (Specify)		9 I	g Crematory Mar.	29,2010	Smithsburg	. Marvland
	permit. Pag Department Important: I any injury o			neral projections			sborne Ademerally Ho			, nary rand
B	permit. Departr Importa any inj		M	118/2/	1/~	4	25 S. Conococheag	ue St.Wi	lliamsport	, MD 21795
			23a. Part Enter the	e disease, or comp tailure. List only o	lications that cause	ed the death. Do not en	ter the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
6	Physician		Immediate Cause (F	Final	· Chrony		e hug Direse with	u Acure	EMISONES	i-2 1+25
	/Medical		resulting in death)		a.	s a consequence of):				
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	sit s	ine	Sequentially list con if any, leading to importance. Enter Under Cause (Disease or in that initiated events	mediate tying	Due to (or a	s a consequence of):	RE			Yones
	and etran	Examiner	that initiated events resulting in death) L	ast	C. Due to (or a	s a consequence of):	ile			10110
68760,	icate be executed physician and s the burial-transit	E E		·		PETENSION				YWARS.
687		edical		•	d					
O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 Unknown	pregnant months? No		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of o Month	delivery Day Year
P.0	res that ti igned by be detad	/ Ph	Part II. Other signifi	cant conditions co	ontributing to death	but not resulting in the t	underlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Sp	uires sign	d by						1 🗆	Yes 2□No 3□	Probably 4 Unknown
of Vital Records,	The law requires that the site has been signed by the page 2 should be detache	Completed						24a. Was	an 24b. Were	autopsy findings available to completion of cause of
Re	The lav	mo							ormed? death	?
ital		BeC	25. Was case referr examiner?	ed to medical			26. Place of De	ath (Check only	one)	
\\	Physicien: this certific ral director,	10	1 Yes 2 1	No	Hospital: 1 ☐ Inpa				dence 6 Other (S	pecify)
	ding Physicien: After this certific funeral director,	on:	27. Manner of Death 1 Natural	n 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time (Day Year) Injury	Wark?	28d. Describe	how injury occurred	
Sio	Attending ir death. ector: After by the fune	catl	2 Accident 3 Suicide	investigation 6 Could not be		njury - At home, farm, s	M 1 Yes 2 No	28f Location /	Street and Number or	Rural Route Number
Division	after of Direction by	Certification:	4 Homicide	determined	208. Place of 1	etc. (Specify)	reet, factory, office	City or To	wn, State)	
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical Co	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	ysician: To the best niner: On the basis and manner:	of examination and/or i	th occurred at the time, date and place	e, and due to the urred at the time,	cause(s) and manner date and place, and o	as stated. due to the cause(s)
	o the	Me	29b. Signature and	title of certifier			29c. License number		29d. Date signed (Mo	onth, Day, Year)
	F 5 F 0			y Och	w /		DULGEI		3.29.	2010 -
			30. Name and addre	ess of person who	completed cause of	f death (Item 23a) (Type		1100 0	a l he l	1 0.50
251	4-7		Gime			90 MT.	AGNO ROAD	1111612	M moin) 71+40
	Sta Regist	ate rar	31. Date filed (Mont	MAR 30 2	010 32. Pogis	strar's Signature	barker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State AMEND#12perFH, 3/26/10BMV, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Robert Kay March 18, РМ 8:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** New York 1 M 2 D F (Month, Day, Year) 19 10, 1922 Director 051-12-9893 87 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11410 Strand Dr. #110 20852 United States permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Unknown 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 K Married 1 X Yes 2 | No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White r Yes, Give Year or Dates. 1941–1955 Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Science Policy Advisor U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Solomon Kay Bess Oichman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doug Kay, Son Dalyn Dr. Potomac, MD 20854 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Crematory 3/23/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 14014/03 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of leart failure List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Left Lobe Pneumonia Medical resulting in death) Due to (or as a consequence of) Examiner Acute Renal Failure Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate use as the burial-transit Cause (Disease or iinjury that initiated events Coagulopathy Secondary to Coumadin resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Possible CVA (Cerebrovascular accident) 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ detached for in the past 12 months? Month 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 2X No Vital Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 XInpatient 2 ER/Outpatient 3 DOA this Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Robert 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contifying Nurse Prantioners T. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. or by uner 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) S. SIVA MIS 3/19/10 065312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 25 2010

MARCH 18

Sudershan Siva 8600 Old Georgetown Rd. Bethesda, MD 20814

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 21 2010 Year Physician/ MARCH 10:43P M 0. A. KARIKARI LORD Medical 4a. Facility Name (if not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign Social Security Number **Funeral** Min JAN 24 1955 Months Davs Hours GHANA Director 577-82-2816 28a-f shov 10d. Inside City Limits 10b. County 10c. City. Town or Location 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State Director ty⊡ Yes 2 ☐ No PRINCE GEORGE'S BERWYN HEIGHTS MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20740 5721 NEVADA STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 🗆 Widowed 4 🗆 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE ENTREPRENEUR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARY YALLEY CHARLES A. KARIKARI 1 and 2 should by Health and Meintem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5721 NEVADA STREET BERWYN HEIGHTS, MARYLAND 20740 GRACE KARIKARI/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1 KBurial 2 Cremation 3 Removal from State 5/1/2010 SILVER SPRING, MARYLAND GATE OF HEAVEN 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME ROAD LANDOVER, MARYLAND 20785 **LANDOVER** 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one caus on each line Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence as the burial-transi Cause (Disease or iiniury that initiated events resulting in death) Last and Due to (or as a consequence of) signed by the attending physician abe detached for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Other (specify) 2 No 9 | Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 🔀 No _ Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ည 1 Yes 2 No 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this 27. Manger of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined after City or Town, State To the Hospital within 24 hours a To the Funeral C completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date; signed (Month, Day, Year) 29c. License number ddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

	•	For State Registrar		Stat	e or wa	ai yiai iu	•			Death		emai riy	Reg. No	00	10	108	352
Physicia	an	1. Decedent's Nam									1	2. Date of De Month		ay 1 8	Year	3. Time of	
/Medic	al	CHARLES			and an arrange or all			45 035	Town	Location	of Dooth	Marc			2010 of Death	2:30	PWI
Examin	er	4a. Facility Name (ha Di	noc	4b. City,		Location	or Death		40		'albo	t	
Funeral		Genesis 5. Social Security N				e (In yrs. lasi		If Under	1 Year_	If Under	24 Hrs.	8. Date of Bi	rth ,			ace (State o	r Foreign
Director		212-22-3	882	6. Sex 1 X M 2□]F	83	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D 0/08/1	926	7)	MARY]	AND	
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arylar shov	5	10a. State	10b. County			10c. City, T		cation								nd. miside Cil 1. XXYes	
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ms 20	Funeral Director	11. Marital Status	GODIA	12. Was	Decedent 8	Ever in U.S.	13. V			ispanic Ori	igin? (Spec	cify Yes or Nican, etc.)		14. Rac	ce - Americ		
after or ite	Ē	1 Never Marr	ried 🛣 Mar	ried 1 🔲	ed Forces? Yes 2](]N s, Give	10		Yes, spec		ın, mexicar Specify:		iican, etc.)			ck, White, e	tc.	
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id be enta ked ic ev	To B	CHARLES	LANG							VIRG	INIA	MAYBER	RRY				
shot and N		19a. Informant's N	lame/Relations	hip (Type. Print	;)		19b. Mailin	g Address	(Street a	and Numb	er or Rural	Route Numi	ber, City	or Town	, State, Zip	Code)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Nental Hygiene. Important: If idem 27 is manked other than "natural" or items 29a or 28a-f show any Injury or other traumatic event, the Medical Examination in the continuation.		NANCY LA	NG/WLFE	3			28539	AUGU	ISTA	CT.	EAST	ON, MI	210	601			
of Heriten		20a. Method of Dis		3 Removal	from State	20b. Plac	e of Dispos etery, crem	sition (Nan natory or o	ne of ther plac	e)	Da	ite	20c. l	Location	- City or To	wn, State	
Pag tment tant: I		4 □ Donation	5 Other (S	3 ☐ Removal Specify)		CHESA						/2010	STEV	VENS	VILLE	, MD	
bepar mpor ny In		21. Signature of Fi	uneral Service	Licensee			22 F .	. Name an ELLOW	id Addres	ss of Facilit	ty NBEIN	& NEW	MAN	FUN	ERAL I	HOME.	P.A.
40 = # O		23a. Part 1. Enter	The of	NC		Ale and a selection	I		-							Approximate	
		shock, or hea	art failure. List	only one cause	on each lin	ne.						respiratory	anesi,			Interval Bet Onset and D	ween
Physician //Medical		disease or condition	on	a/	Tau	es p	alla	ne 1	011	hriv	2				- 1	weeks	>
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the d	ysid	1 □ Yes 2 9 □ Unknowr			Unknown	t unite of dea	5	other (ap	<i></i>								
that ned b	by Pt	Part II. Other signi	ificant conditi	ons contributing	to death bu	ut not resultir	ng in the ur	nderlying ca	ause give	en in Part I		23e. Did	tobacco	use con	tribute to th	e cause of d	eath?
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or At after o Direct in by	Certification:	4 ☐ Homicide	detern	inod 286. I	Place of Injubulged	ury - At home c. <i>(Specify)</i>	e, farm, stre	eet, factory	, опісе		21	Bf. Location City or To	(Street a wn, Sta	and Numi te)	ber or Hura	I Houte Num	ber,
To the Hospital or Attending Physician: The law requires that the death cenwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier	Certifyin	ng Physician:	To the best of	of my knowle	edge, death	occurred	at the tir	ne, date a	nd place, a	ind due to th	e cause	(s) and m	nanner as s	tated.	
e Hos 124 h e Fur letely	Medical	(Check only one)	€ Medical	Examiner: On	the basis of manner sta	f examination	and/or in	vestigation	, in my o	pinion, dea	ath occurre	d at the time	, date a	nd place,	and due to	the cause(s)
To the comp	Me	29b. Signature and	d title of certifie	Mas	2/11	11		290	. License	e number		-10	29d. D	ate signe	ed (Month,	Day, Year)	
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10		30. Name and add	ress of person	who completed	cause of de	eath (Item 2				1_	,	Tin			^-	01-5	. /
10		MICHARL	- CROC	Y MEY L	71)	610	DV	all all	ANS	M	NE	1-49	STON	1 <u>l'</u>	ID	2160)(
Sta Registra	.6	31. Date filed (Mor			32. Registra	ar's Signatur	•		,								
Registr	वा		MAR 22	2010	Denew	1. C	7.	arra									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMEND#P-1+2perMD, 3/25/10, BWW, McCo Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day P^{M} Phyllis Medical Levin 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Southern Maryland Hospital Prince Georges If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington DC **Funeral** Age (In vrs. last birthday 8. Date of Birth Months (Month, Day, Yes 01/20/194 Hours Min 1 M 2 X F Director Yrs. 63 215-52-5094 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Montgomery <u>Rockville</u> 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 6111 Montrose Road 20852 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 X Never Married 2 ☐ Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 Divorced 4 Divorced Year or Dates White It of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <u>Legal</u> Aide Lega] Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leon Levin Zelda Spund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Spund / Uncle 20a. Method of Disposition Holmes Run Parkway #806 Alexandria, VA 22304 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/15/2010 Shel Emmes Chesed Capital Heights Signature of Funeral Ser 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc. 170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X(No Other: 1 🗌 Yes ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 - Pending work 1 🗌 Yes 2 🗌 No Accident within 24 hours after death To the Funeral Director: Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 09

State Registrar 31. Date filed

KA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per TNF G902 4/08/2010 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2010 1115a M Mae LaRue Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Se (Month, Days Year) | 1915 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Social Security Number 19 1 □ M 2 🔯 F Mary land Director Usual Residence of Decedent or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 72 hours after death with the Maryland Director 1 1 Yes 2 □ No Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11 Harp Place 21773 or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify; "natural", 3 X Widowed 4 ☐ Divorced Specify: White Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within i Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any injury or other traumatic event, the M College (1-4 or 5+) Coil and Relay Assembler Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Harry Davis Rohrer Sarah Elizabeth Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7608 Picnic Woods Road, Middletown, Maryland 21769 Eric Main/grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Zion Lutheran Apr.6, 2010 Middletown, Maryland 504 Main Street 21. Signature 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final A CU TE Physician/ MYOCAMBIAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): g physician and as the burial-transit RERENT Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical TRACT INFECTION Division of Vital Records, P.O. Box 68760 attending pl IE EMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of cert 29c. License number D0062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Agyako-Wiredumo
31. Date filed (Month, Day Year)

32. Registrar's Sign 251 East antiekum St. Hagerstoon, MD 21740 32. Registrar's Signature State Registrar

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State State Registrar 1. Decedent's Name (First, Middle, Last)	Ce	ertificate of Dea	2. Date of		010	1 0 8 5 3. Time of Death
hysician /Medical	1	Howard Reno MORNINGS	TAR		Month Marc	h 28,	2010 ^{Year}	1:17 8
xaminer		ta. Facility Name (If not institution, give street as Homewood at Williams		4b. City, Town, or Loca		1	County of Death Washing	
neral ector		5. Social Security Number 6. Sex 1監 M 2日	7. Age (In yrs. last birthday 73 Yrs.		nder 24 Hrs. 8. Date of urs Min. (Month Marc	Birth Day, Year) h 26,	Cou	pplace <i>(State or Fore</i> <i>intry)</i> Maryland
×	-	Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or I	Location				10d. Inside City Lir
led a		Maryland Washington	Ha	gerstown				1 ☐ Yes 2 🔀
or 28a-1 st be notified	2	10e. Street and Number		10f. Zip Code			zen of What Cou	intry?
23a c		1264 Frederick Street		21740			SA	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examinar count by nutilised at once. To Be Completed by Finneral Director	<u>~</u>	Arm 1 □ Never Married 2 ☑ Married 1 ☑ If Ye	s Decedent Ever in U.S. ned Forces? IYes 2 □ No 1955- es, Give ar or Dates: 1958	3. Was Decedent of Hispan If Yes, specify Cuban, Me 1 □Yes 2 ☒ No Sp	ic Origin? (Specify Yes o exican, Puerto Rican, etc.		14. Race - Amer Black, White Specify: W	
t, the Medical E	biered	15. Decedent's Education (Specify only highest grade compi	leted) 16a. Dec (Giv leted) (Iife	cedent's Usual Occupation we kind of work done during . DO NOT use retired)	most of working	1	nd of Business/I	,
	Ę	12	lege (1-4or 5+) tr u	ick driver			truck m	ig.
d other		17. Father's Name (First, Middle, Last)		18.	Mother's Name <i>(First, Mic</i> Carrie Smit		Surname)	
arke atic	<u> </u>	Theodore Morningstar		illing Address (Street and N			r Town State 7	'in Cadal
27 is m er traum		19a. Informant's Name/Relationship (Type. Prir Lisa Wallace – daught	·	White Oaks		sburg,	WV 254	04
nt: If item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)		position (Name of rematory or other place) own Crematory	7 3/30/2010		cation - City or T	Fown, State Maryland
Importa any Inju once.		21. Signature of Funeral Service Licensee	in Oe	22. Name and Address of 415 E. Wilso				
cician and crial-transit miner	ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Luna CA	vcer.			10 munn
	Physician/Medical	in the past 12 months?		3 Ectopic pregnancy 5 Other (specify)			23d. Date of del Month	Day Yea
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cate has beer	Completed					Was an autopsy performed? 'es 2≅No	prior to death?	utopsy findings ava completion of caus
irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 Mo Hospita	ul: 1 ☐ Inpatient 2 ☐ ER/Outpa	Othori	Place of Death (Check of Death		6 ∏Other (Spe	ecify)
	0 :u	27. Manner of Death 1 ★Natural 5 Pending	a. Date of Injury (Month, Day, Year) 28b. Time Injur	e of 28c. Injury at	28d. Desc	ribe how injur		J.,
: After thi	윭ㅣ	2 Accident		street, factory, office	28f. Locat	ion (Street ar or Town, State	nd Number or R	ural Route Number
I Director: After this id in by the funeral of	Sertificatio	E E Trooidoin	e. Place of Injury - At home, farm, building, etc. (Specify)		City			
e Funeral Director: After thi	dical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e 29a. Certifier (Check only 2 Medical Examiner: O	Place of Injury - At home, farm, building, etc. (Specify) To the best of my knowledge, do not the basis of examination and/ond manner stated.	eath occurred at the time, o	date and place, and due t	o the cause(s time, date and	s) and manner a d place, and due	s stated. e to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 25,2010 10:55 A M Anna Mary Mason /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5018 General Stuart Court Sharpsburg Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Dec. 28, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Year) 1 □ M 2 🔀 F Months Davs Hours 215-18-1850 92 1917 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits s 23a or 28a-f show ust be notified at Director 1 DXYes 2 □ No Maryland Washington Sharpsburg 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 5018 General Stuart Court 21782 USA Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian T is marked other than "natural", or items traumatic event, the Wedent Examination Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Rivoter Aircraft Manufacturer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, II 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be ပ Otho Churchey Nora Ann Tucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Mason (Daughter) 5018 General Stuart Ct. Sharpsburg, Maryland 21782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) View Cemetery March 29, 2010 Sharpsburg, Maryland Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, Maryland 21795 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 YEARS ongestive disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar Due to (or as a consequence of) attending physician for use as the buria YEARS Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Certification: 5 Pending investigation 1 □Yes 2 □No after death

Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

requires that the death certificate be executed Box 68760, P.0. Records, Division of Vital death.

Maryland 21215-0036

Baltimore,

Hospital or Attending Physician: in 24 hou. • the Funeral Dire.. • '~\v filled in by th the within 2

State Registrar

(Check only one)

29b. Signature and title of certifier

29c. License number D 44996

29d. Date signed (Month, Day, Year) 20/0 March 26,

30. Name and oddress of person who completed cause of death (Item 23a) (Type 2014) (Type 2014)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patricia Davis Mortimer March 1¹6⁹y 2**0**TO 4:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 T F Months Days Hours March Day Year 1935 578-64-5474 Director 75 Jamaica Vrs Usual Residence of Decedent shov 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f sh notified MD 1 X Yes 2 No Montgomery Silver Spring 10e. Street and Number ö 10f, Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 11235 Oak Leaf Drive #1008-B 20901 United States Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant; if tem 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black. If Yes, Give Year or Dates 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lester Wilford Davis Dorothy Imogene Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901 Margaret Jill Mortimer/Daughter 11235 Oak Leaf Drive #1008-B Silver Spring, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important; If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery | 3/25/10 Washington, D.C. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, DC 20012 23a. Patr 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Stage IV Mullerian tumor of the uterus disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death je je ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Certificate: To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy performed? Yes 2 N certificate 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician; The law requires that the death certificate be Box 68760 P.O. Division of Vital Records, ...er death. ..eral Director: After th: d filled in by the fur-To the Hospital within 24 hours a To the Funeral D

Maryland 21215-0036

Baltimore.

(Check 2 ∐ N	Certifying Physician: To the best of my knowledge, death on Medical Examiner: On the basis of examination and/or invest Certifying Nurse Practioner: To the best of my knowledge, d	tigation, in my opinion, death occurred at the time, of	late and place, and due to the cause(s) and manner stated.
29b. Signature and title of	of certifier	29c. License number	29d. Date signed (Month, Day, Year)

5

D0060634

March 19, 2010

30. Name and address of persort who completed cause of death (Item 23a) (Type, Print)

Bindu Joseph, M.D. 6001 Muncaster Mill Rd., Rockville, MD 20855

State Registrar

Medical

31. Date filed (Ma

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Leoma Christine Mitcham 12:40 pm March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. July 24 313-14-4736 Indiana Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director Examiner must be notified 28a-f 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 9 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 20901 U.S.A. 11110 Oak Leaf Drive death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: African-American 'natural", Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Home Economics Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lucille Hathecock Paul Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 6711 Brigadoon Drive. Bethesda, Maryland 20817 Christopher Mitcham - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parklawn Memorial Pk. 03/29/2010 | Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Ischemic Colitis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a g Unknown 9 | Inknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Endstage Renal Disease 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has i autopsy page death? 2 X No 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: Division of Vital æ 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 X No 1 Yes မြ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of n 24 hours after death.

e Funeral Director: After the beted filled in by the funeral 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) March 23, 2010 D0062435 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive, Rockville, Maryland 20850 Sayed Eisayyad. MD 2. Registrar's Sign yea 5 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ForState	State of Ma	-	•			Mental Hy	gien	e	
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Physicia Medic		GERA		cALLEN				Month MARCI		3, Year 201	
) Examir		4a. Facility Name (if not institution, give			4b. (City, Town, or	Location of Death			c. County of Dea	
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land 21215-0036 be filed within 72 hours after death with the Maryland ental Hyglene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)			11.01		18. Mother's Nan	ne (First, Middle,			7 1 1 41 1
Ylal	욘		F. McALE	ER			MAI	RGUERITE	E A	. BLES	SING
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (MARGARET A. TA)		l			nd Number or Ru				,
		20a. Method of Disposition		20b. Place of	Disposition (Name of	/E., NOR	Date DEACE		_ocation - City or	
Page 1 ment of ant: If it		1 ☐ Burial 2 ☐XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec				or other place REMATOR		5-2010	R	IVERDALI	E, MD.
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other	,	21. Signature of Funeral Service Liber	M POINTO	м00091	22. Name	e and Address					
		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused t							E. MD.	Approximate
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6876 certificat nding ph	/Mec	IF FEMALE:	220 16.000								
Box 6 death ce the attendance for us	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t	☐ Fetal death	3 Ector	pic pregnancy	/			23d. Date of de Month	livery Day Year
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DIVISION OF tal or Attending Ph rs after death. al Director. After th ed in by the funeral	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day,	Year) 28b. Tir inj	me of ury M	28c. Injury work?	at ∕es 2 □ No	28d. Describe h	now inju	ry occurred	
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Division of Vital To the Hospital or Attending Physician: We the Funeral Director. After this certific completed filled in by the funeral director,	Medical	(Check 2 L Medical Exam	ysician: To the best of m nîner: On the basis of exa rse Practioner: To the be	mination and/or	investigation	, in my opinion	n, death occurred a	at the time, date a	and place	e, and due to the	cause(s) and manner stated.
Som Com		29b. Signature and title of contifier	M/01	- M	,	29c. License				ate signed (Monti	
5		30. Name and address of persop who	completed cause of doc	th (Item 23a) /Ti	me Print\	457	532		Mo	uch 27	, 2010
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Sta Registra		31. Date filed (Month, Day, Year) MAR 25 2010	32_Registrar	Cianatura	Kel						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:54p March 22,2010 Julia Martinez de Bermudez Maria Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Gaithersburg 10317 Ridgeline Drive 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-57-2102 1 □ M 2 😿 F Months Days Hours Min. 1 1 2 1 3 av, Year) 9 2 7 El Salvador 82 Director Usual Residence of Decedent 28a-f shov 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director MD Montgomery Gaithersburg 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 10317 Ridgeline Drive 20886 El Salvador 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. 1 Never Married 2 Married ò Completed by Yes 2 X No altimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: El Salvadoren If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home it. Page 1 and 2 should be filed with thement of Health and Mental Hygien trant; If item 27 is marked other 1 jury or other traumatic event, the straumatic event, the straumatic event, the straumatic event, the straumatic event is straumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Martinez Genaro Martinez Saba Reyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10317 Ridgeline Drive Gaithersburg, Md20886 Rose Marina Martinez/Daug. 20a, Method of Disposition 20b. Place of Disposition (Name of San Vicente, El Salvador Date Department of Important; If it any injury or o 1 Burial 2 Cremation 3 Removal from State Cemeter cremetory or other place) 3/29/2010 4 Donation 5 Other (Spegify) PHILIPADES RIWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stars disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Exami I or Attending Physician: The law requires that the death certificate be executed after death. been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2. autopsv 2**X** No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar CRNP

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christenson

Nicole Day, Year

31. Date file

1190618

March 25,2010

6001 Muncaster Mill Rd Rockville, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🥎 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2¹3^{ay} Physician/ 201 O 8:10 P MARCH MCCOY DESSIE R. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 1118 60th AVENUE FAIRMONT HEIGHTS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year JULY 31 1 Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 ☐ M 2 ☐XF Months Days Hours Min. SOUTH CAROLINA 91 **Director** 1918 579-28-7204 Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 28a-f 1 x Yes 2 ☐ No FAIRMONT HEIGHTS MD PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 1118 60TH AVENUE 20743 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. δ ☐ Yes 2 🛣 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9th DOMESTIC PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SAMUEL T. BAILEY THEDA BORDERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID MANUEL/NEPHEW 1514 3RD STREET GLENARDEN, MARYLAND 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 3/27/10 LANDOVER, MARYLAND ture of Funday Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner ATRIAL FIBRILLATION Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit DEMENTIA that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death 9 Unknown is certificate has been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 Ves 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 \square Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical

State Registrar

29a. Certifier

only one) 29b. Signature and title of cert

6201 GREENBELT ROAD # U15 COLLEGE PARK, MARYLAND IKECHI OKWARA M.D. 31. Date filed (Month, Day, Year) 32. Registra s Signatur MAR 2 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

MARCH 24, 2010

20740

29c. License number

D4335

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 1:33 p. Michael Joseph Ohrin March Medical 4a. Facility Name (If not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 40781 South 40 Drive Leonardtown 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 K M 2 🗆 Months Days Hours Min. Yrs Pennsylvania **Director** 80 196-22-5698 Usual Residence of Decedent show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 40781 South 40 Drive 20650 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: Completed 3 X Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important. If item 27 is marked other i any injury or other traumatic event, th Tool & Dye Maker Industrial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dolny Joseph Ohrin Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Bohannon/Fiance 40781 South 40 Drive, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛣 Burial 2 🗌 Cremation 3 🗀 Removal from State Kenilworth, NJ 04/06/2010 Graceland Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Rd., Leonardtown, MD 20650 Simons MO1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on pactyline. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed Exam and tran resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) ed by the a detached 1 2 No 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 100 3 Probably 4 Unknown Completed 1 Yes page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autonsy perforn death? certificate N6 1 Tes 1 Yes or Attending Physician: Be Was case referred to medical 26. Place of Death (Check only one) Hospital No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this funeral Manner of Aath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Vatural injury 5 Pending 1 ☐ Yes 2 ☐ No after death 2 Accident
3 Suicide Investigation Funeral Director: eted filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital hours Medical 29a. Certifier Certifying Physician: The best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Exami (Check the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Myrs within 2 only one) actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 10

BA

State

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

strar's Signature

₹680 Miss Bessie Dr., Leonardtown, MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Boyd,

és C.

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b&c per FH G902 4/8/10 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 10864 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 20^{Year}_{0} **Physician** APRIL **FUOSS** PARSHALL GEORGETTE 9:00P M LOIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CHARLES GENESIS LA PLATA CENTER LΑ PLATA 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 4,1934 PENNSYLVANIA 1 ☐ M 2 🔀 F Months Days JULY Director 211-26-2269 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygtene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat neual be notified at once. 1XYes 2 No Director CHARLES LA PLATA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code S. A. 20646 U. 6313 TERESA LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: WHITE Completed by 3€Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELEMENTARY SCHOOL TEACHER'S AIDE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MABEL NOAL J. HAROLD FUOSS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6401 ERVIN ROAD ATHENS, OHIO 45701 JO ANN BALL / NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4/7/2010 Bellwood, PA Logan Valley Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service Licensee four MD 20646 5635 WASHINGTON AVE., LA PLATA, M00641 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ALLUPIE MONAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): MONTUS Examiner SEP 315 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month Day Year 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 1 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural n 24 hours after death.

Ne Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi 20 D0006018 mo 30. Name and address of person who co npleted cause of death (Item 23a) (Type, Print) King GFOON VA 17064 FEDRY WOLL KICHM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State porte Registrar

27

DHMH 17 Rev 1/2001

ORIGINAL

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Physician Medical Examiner 23a. Part I. Enter the disease, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate decays (Final dasase are condition resulting in death) Sequentially list conditions. If any, leading to immediate events resulting in death) Sequentially list conditions. If any, leading to immediate events resulting in death but to to for as a consequence of): Due to (or	altil mit. partm porta jury o	Ì				1	22. Na	me and Ad	dress of	Facility I	E. F	. Las	sahn	Fune	ral	Home. F	P.A.
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The mediate Cause (Final disease or condition resulting in death) The part of the part of				e on each line.			. Do not enter the	e mode of d	lying, su	ich as card	liac or re	espiratory a	rest, sho	ck, or hear		Between On:	set and
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Very Section of the state of th		<u>=</u>	if any, leading to immediate		r as a cons	equence c	f):										
UNPENDED AMENDED AME	1.		(Disease or injury that initiated		r as a cons	equence o	f):								-	-	
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FFEMALE: FFEMALE: 23d. Date of delivery Month Day Year			UNPENDED	AMEN	DED									0-2			
Part II. Other significant conditions Column	376(ificate ig physis the b	Ž	3b. Was decedent pregnant in t	La		me of preg		Ldoath	3 🗆	Ectopic pr	eananc	,				v Ye	ear
Part II. Other significant conditions Column	x 68 th cert ttendir r use a	<u> </u>		4 🗔		time of de	- H		_	- cropio pi	ogao					,	, . .
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 3, 2010 30. Name and address of person who completed cause of death (Item 23a)	Bo lee deat the at the at red for	Š.		a					.,								
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 3, 2010 30. Name and address of person who completed cause of death (Item 23a)	duires										_						
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 3, 2010	ne Hos n 24 h ne Fur		(Check only 1 Certifying P	-													
30. Name and address of person who completed cause of death (Item 23a) O.C.M.E. April 3, 2010	To the within To the comp	[]	, Z w medicar zm	and man		ililiation a	- Ind/Of Investigation				ied at til	e line, date					
30. Name and address of person who completed cause of death (Item 23a)		-		1 1	1		10								•	., = ., r dai j	
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				•		. /		Street,	Baltim	ore, MD	2120	1					
State 31. Date filed (Month, Day, Year) 32. Register's Signature Registrar			31. Date filed (Month, Day, Year)					2 - 6	-0				-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 28 21 denour Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Washington Examiner Washington County Hospital Hagerstown Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Age (In yrs. last birthday) Days (Month, Day, 214-32-4473 1 🗆 M 2 🔀 F 81 Director 12, 1928 <u>Sent.</u> Maryland Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Boonsboro 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 Orchard Drive 21713 U.S.A. 11 Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No 1 ☐ Yes 2 M No Specify: Specify: White 3 X Widowed 4 Divorced "natural" Year or Dates Health and Mental Hygiene.

em 27 is marked other than "natur ther traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Weaver Frisby Moser 2 Della Ellen Bowman Moser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21017 Track Side Road, Smithsburg, Maryland 21783 Dennis E. Unger/ Executor item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion Cemetery 04/01/2010 Boonsboro, Maryland 21. Signature of Furneral Service Licenses Bast-Stauffer Funeral Home Pike, Boonsbore, MS ac or respiratory arrest, 7606 Old-National 23a. Part . Enter the disease, or complications that c. used the shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** arrey extramily Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No detached g | Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ankle 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performe 2 No Yes 2 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and t 044996 Theme Id Coonform MD 257/3

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

	1	For State Registrar	Plea				id / Depa		k. Ensure A Health and N Death	Mental Hy	giene	Legible		7
Physician/ Medical	I	1. Decedent's Name	M. S	PIKER				modelo or E	Journ	2. Date of Dec Month 03	Reg. No.	2010	3. Time of Deat 9:08 P	
Examiner		ta. Facility Name (if	HOSPI C E	-	d number)			4b. City, Town, or	Location of Death EASTON			ounty of Dea		
Funeral Director		5. Social Security Nu 212-48-87 Usual Residence of	716	6. Sex 1 □ M 2 2	7. A	ge (In yrs. Ia 65	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month Da 08/23/	1944		thplace (State or Fore Unitry) XYLAND	eign
or 28a-f show notified at Director	- 1	10a. State	10b. County	TDOM		10c. Cit	y, Town or Loc						10d. Inside City Lin	
with the M. 23a or 28 ust be noti		MARYLAND 10e. Street and Num 7050 OXE	nber	AD			EASTO	10f. Zip Code	1601		_	en of What Co	ountry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Deg attment of Health and Mental Hygiene. Deg attment of Health and Mental Hygiene. Important: If them Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	2	I1. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		ied 1 I	Decedent ed Forces? Yes 2 2 s, Give or Dates.	Ever in U.S	If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🏅 No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame Black, Whit pecify: WH	e, etc.	
rithin 72 hours at lene. r than "natural" the Medical Exc	-	(Spec	cify only highe:		leted) ege (1-4 or	5+)	(Give F life. D	NOT use retired)	ation luring most of work			of Business	,	
be filed wit brital Hygie ked other c event, th	1	17. Father's Name (F	First, Middle, L	,	4		1	EACHER	18. Mother's Nam		Maiden Su		SCHOOL	
ath and Me 27 is mar r traumati	- 1	19a. Informant's Na	me/Relationsh	ip (Type, Print)			1	-	and Number or Rura	al Route Numbe	r, City or To		o Code)	
Fage 1 and nent of Hes ant: If item iny or othe	4	20a. Method of Disp 1 Burial 2 4 4 Donation	X Cremation	3 ☐ Removal	from State	e c	Place of Dispos emetery, crem	sition (Name of natory or other plac		Date	20c. Loca	ation - City or		
permit. Der artr Importa any inju		21. Signature of Fun	neral Service Li	censee			22	Name and Address	s of Facility				HOME, P.	A.
hysician/ Medical Examiner		23a. Part 1. Enter the shock, or hear Immediate Cause (fidisease or condition resulting in death)	rt failure. List o Final n	a	on each lin	ie.	CANC	r the mode of dying	g, such as cardiac c	or respiratory an	est,		Approximate Interval Between Onset and Death	
/sician and e burial-transit		Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	nmediate rlying iinjury	c	_	a consequ								_
within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exami		F FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	23c. If yes	Live Birth	e of pregna 2 Feta at time of c	al death 3 🗌	Ectopic pregnanc Other (specify)	у		23	d. Date of de Month	livery Day Year	
n signed build be deta	1	Part II. Other signifi	icant condition	ns contributing	g to death	but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	,		the cause of death?	
cate has been si page 2 should t										24a. Was a autop perfo	an an an an an an an an an an an an an a	prior to death?	topsy findings availal completion of cause s 2 \(\sum \) No	ble of
nis certific I director,	ı İ:	25. Was case referre examiner? 1 \(\sum \) Yes 2	ed to medical ≰No	Hospital:	1 Inpat	ient 2 🗆	ER/Outpatien	Otho	ace of Death (Checker:	k only one)	lence 6 X		ify HOSPICE	
after death. Director: After the in by the funeral Certificate:		27. Manuer of Death 1 Natural 2 Accident 3 Suicide	5 Pending Investig	ation	Date of inju (Month, Da		28b. Time of injury	28c. Injury work' M 1 🗀	at	28d. Describe h				
urs after d eral Direct illed in by:		4 Homicide	determi	ned 28e. I	ouilding, et	c. (Specify)	et, factory, office		City or Tow	n, State)		ral Route Number,	
thin 24 hours the Funeral mpleted fillec		(Check 2 only one) 3	Medical Ex	caminer: On th	e basis of	examination	and/or investi	gation, in my opinio eath occurred at the	time, date and place	the time, date a e, and due to the	nd place, ar cause(s) a	nd due to the nd manner as	cause(s) and manner s stated.	stated.
72S		29b. Signature and t	120 =	HOW	M				7887		29d. Date s	3 19		
5		DR. DAVI 1. Date filed (Month	D SMITH	1,MD 8	221 3	EAL I	DRIVE,	STE 301,	EASTON,	MD 2160)1			
State Registrar	8		R 2 2 2		Registr	ar's Signat	. fa	Ked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Joseph Thomas Stewart, Sr. 11:30 P M 30 March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 42964 St. John's Road Hollywood St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 🛛 M 2 🗆 F Months Hours Min Maryland Director 213-40-8504 67 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20636 42964 St. John's Road USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Black. Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Beatrice Somerville John Henry Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12314 Smoot Way Joann Denise Speaks / Daughter Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State injury or 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State April 10. 4 Donation 5 Other (Specify) Charles Memorial Gardens Leonardtown, Maryland 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home,
P.O. Box 270 Leonardtown, MD 200 Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, Metastatic Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) 1/23/10 2 morth Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number minor Shuh 29d. Date signed (Month, Day, Year) MD D0068120 3-31-10

State Registrar 23415 Three Notch Road, California, MD 20619

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Minal M. Shah, MD.

31. Date filed (Month, Le Deur)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760 he Hospital or Attending Physician: The law requires that the death certificate be executed

		For State	Plea	se Type o r State o			d / Depa	artment	of H	łealth		III Copie Iental Hy		_	le.	1000	0
Physicia		Registrar 1. Decedent's Name Gilbert F			 Stri	cker		rtificate	of L)eath		2. Date of De 3 / 23 / 2			ar	3. Time of Death 10:42 P	м
Medic Examin Funeral		4a. Facility Name (if 131 Windj 5. Social Security N 219-01-49	not institution, ammer F	give street and nun	nber)	-	st birthday)	4b. City, 1 Ber1: If Under Months	Ln		of Death	8. Date of Bi	4 We	c.County of E	er	lace (State or Foreig	
Director -t show led at	ctor	Usual Residence of 10a. State	Decedent 10b. County			10c. City,	Town or Lo	cation				11/2//	1920	<u> </u>		0d. Inside City Limit	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	MD 10e. Street and Nun 131 Windj				Ber1	in	10f. Zip					10g. C	Citizen of What	t Coun		-
urs after death ural", or item il Examiner n	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		12. Was Dece Armed Fo ed 1 1 2 Yes If Yes, Giv Year or D	rces? 2 🗌 N re			Was Decede f Yes, speci	fy Cubai	n, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - A Black, W Specify:		etc.	
within 72 hou giene. Ier than "nat It, the Medica	Completed	(Spe		t's Education t grade completed College (1		+)	(Give . life. D	dent's Usual kind of work O NOT use untan	(done d retired)		st of worki	ing		Kind of Busine		lustry	
nould be filed nd Mental Hy s marked oth umatic event	To Be	17. Father's Name (in William S	Stricker	c			19b. Mailir	ng Address		He1e	n Go	e (First, Middle onan al Route Numb			, Zip C	ode)	_
ge 1 and 2 short of Health and the strain and train and train or other trains			position Cremation	3 Removal from		ce	ace of Dispo metery, crer	osition (Nam natory or oti	e of her place	e)	1	in, MD	20c.	Location - City		wn, State	
permit. Pa Departme Importani any injury		4 ☐ Donation 21. Signature of Fu	5 Other (Sp			שויון						0/2010 Burbag rlin, M		lock, uneral 1811		me	
Physician/ Medical Examiner		Immediate Cause (disease or condition resulting in death)	rt failure. List or (Final on	a.	ach line.		50	er the mode		g, such as	s cardiac d	or respiratory a	rrest,		+	Approximate Interval Between Onset and Death	
ric ar	dical Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated event resulting in death) l	nmediate rlying iinjury s	Due to	,	conseque									+		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth 2 nant at	of pregnan 2 Fetal time of de	death 3	☐ Ectopic p ☐ Other (spe		у				23d. Date of Month		ry Day Year	
requires that the been signed by should be deta	by	Part II. Other signif	ficant condition	ns contributing to c	leath bu	it not resul	Iting in the u	underlying c	ause giv	en in Parl	t I.		Yes 2	2 □ No 3 □	Prob	e cause of death? ably 4 Unknow sy findings available	
cian: The law ertificate has ector, page 2 s	Be Completed	25. Was case referre		Hospital:					26. Pla		ath <i>(Ch</i> ec	auto	opsy ormed?	prior deat	to cor h?	npletion of cause of	
ending Physieath. or: After this cothe funeral dire	Certificate: To	1 Yes 2 27. Manner of Death 1 Natural 2 Accident 3 Suicide	h 5 Pending Investig. 6 Could n	28a. Date (Mon	of injury	y Year)	R/Outpatier 28b. Time of injury	f 28	kc. Injury work 1	4 L N		me 5 Res 28d. Describe			pecify)		
ospital or Att hours after d uneral Direct ed filled in by	Medical Cert	4 Homicide 29a. Certifier 1	determi	ned 28e. Place build	est of n	(Specify) ny knowle		occured at t	he time,			City or To	wn, Stat ause(s) a	e) and manner as	state		
To the H within 24 To the Fu complete	Med	29b. Signature and	Certifying title of certifier	Nurse Practioner:	To the b	est of my l	knowledge,	death occurr 29c.	ed at the License		e and plac		he cause 29d. D		r as sta o <i>nth, E</i>	Day, Year)	led.
N 6+1 Stat		30. Name and address MUNN 31. Date filed (Montal	th, Day, Year)	32. F	1110	r's Signatu	acetro	ech R	ead		Ber (i)	n, MD	ટા8	<i>(</i> (
Registra	ir		MAR 24	2010 🔏	nece	4	2. 10	arres									

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			1 - State Registrar	State of Mary	-	artment of H	- 10		ene (0	108	70
			Decedent's Name (First, Middle, Last	st)				2. Date of Death	- I	14	3. Time of	Death
	Physici /Medic		MHG. LOHA	L SEIBERT				Month 3	Day 28	2010	11.35	5 PM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death		4c. County			
		н	Coffman Nursing	Home		Hager	stown		Wash	ingto)Ti	
	Funeral		Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State o	r Foreign
	Director		214-09-0686	10	13 Yrs.			11.18.			/land	
	and *		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				1	0d. Inside Cit	ity Limits
	Aaryli F sho	ō	36 1 . 1 . 77 . 1 .		77						1 🗌 Yes	
	28a-	ect	Maryland Washing 10e. Street and Number	ton	Hagers	10f. Zip Code		10	g. Citizen of	What Cour	ntry?	
	with	ä	1304 Pennsylvania	Augnio		2174	0		•		,	
	ns 23	Funeral Director	11. Marital Status	12. Was Decedent Ever		Was Decedent of H	lispanic Origin? (Sp.	ecify Yes or No-		ce - Americ		
(0	r iter	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 No		If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Bta	ck, White,	etc.	
036	urs a al', o Exer	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specif	y: Wh	nite	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23s or 28s-f show event, the Medical Examinating the neutiling at	Completed	15. Decedent's Ed (Specify only highest gra	(ucation		dent's Usual Occup		ina 1	6b. Kind of B	usiness/In	dustry	
2	thin e.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	<i>a)</i>	9				
7	e filed w al Hygier I other th vent, Illu	S	8	00		Cook			Restau			
pu	tal H d oth	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M.	aiden Sumar	ne)		
3	2 should be and Mental is marked sumatic ev	10	William Henry Loh		40. 14. 11		Maude		0: -		0 ()	
Maryland	12 st h and 7 is n traun		19a. Informant's Name/Relationship (ng Address (Street a						
	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic	1 5	Teresa A. Wagner 20a, Method of Disposition	- G. Daughte	er 1891. Ob. Place of Dispo	3 North M	leadow Boa	d, Hager	Oc. Location	- City or To	21742	
Baltimore,	permit. Pages: Department of H Important: If ite any injury or ot	4.7	1 🕅 Burial 2 🗍 Cremation 3 🗆	Removal from State	cemetery, cre	matory or other place	(e)					
Iţiu	it. Partment	b i	* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer			ing Cemet 2. Name and Addres					e, Mar	yland
Ba	permi Depar Impo any ir		2000	7.				Minnich				710
			23a. Part1. Enter the disease, or com	plications that caused the		15 E. Will				laryla	Approximate	9
	CONTRACT TO SERVICE		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					,		Interval Bety Onset and I	Death
	Pnysician /Medical	11	disease or condition resulting in death)	a / I O CAR Due to (or as a cor		M GALLER	ラ パ			-	5-101	Min
	Examiner					RYTHMIA.					YEMES	
	왕	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cor		~[[]] []	,				1 (1)165	
	uted d ansit	Examine	Cause (Disease or injury that initiated events	· 1200 5	TME	DEMENTIN	١				THIRS	
o,	an an rial-tr		resulting in death) Last	Due to (or as a cor	sequence of):							
8760,	ate be executed hysician and the burial-transit	dical		d								
9	ng ph	Med	IF FEMALE:									
Box	death certific e attending p od for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		Ectopic pregnancy				ite of delive	,	Year
Ö.	0 0	Sici	1 Yes 2 No	4☐ Pregnant at time 9☐ Unknown	of death 5	Other (specify)			IVIC	21101	Day	real
P.O.	ac ac	Phy		antilla time to denth had an	t ennutring in the co		i- D-+!	23e. Did toba		tributo to th	no pouso of d	ioath?
		by	Part II. Other significant conditions of	onthouring to death but no	rresulting in the o	moenying cause give	en in Fait i.		2 🗆 No	3 [] Prob	٩.	Unknown
oro	requires seen sign hould be	ted						Testing devices	2 19			
ec	@ 2 C/I	Completed						24a. Was an autopsy	24b.	Were auto prior to co	psy findings a mpletion of ca	available ause of
=	Th ate pag	Cor						perform 1 Tes 2	ea? No	death? 1 🗌 Yes	2 No	
/ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		O#		h (Check only one				
of	Phyaician: this certific ral director,	70	1 ☐ Yes 2 💯 No 27. Manner of Death	1 L Inpatient	2 ER/Outpatie		4 Nursing Ho	me 5 Resider			y)	
no no	ling f	ion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Worl	yat k? Yes 2 □ No	28d. Describe hov	w injury occur	rea		
isi	Attanding it death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		At home farm st			28f. Location (Stre	eet and Numl	her or Rura	al Route Num	her
Division of Vital Records,	lor A after Dirac	Certification:	4 ☐ Homicide determined	building, etc. (Sp	pecify)	reer, ractory, office		City or Town,	State)	567 G7 71676	3 7 10010 7 VOIII	DG/,
_	Hospital or 24 hours afte Funaral Dir etely filled in		29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge deat	h occurred at the tin	ne, date and place.	and due to the cau	use(s) and ma	anner as s	tated.	
	To the Hospital or Attanding Phyalcian: within 24 hours after death. To tha Funaral Diractor: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examone)	niner: On the basis of examiner and manner stated.	mination and/or in	vestigation, in my o	pinion, death occur	red at the time, dat	te and place,	and due to	the cause(s)
	To the h within 24 To tha F complete	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signe	d (Month,	Day, Year)	
	0		> HOole			1)4	P6561		3.29	10		
			30. Name and address of person who	completed cause of death	(Item 23a) (Type,							
5	4-1		GITAZALA DA		70 MT	AEMA /	LOAD F	tagins rou	IM ME	0	4740	5
	Sta	- 200	31. Date filed (Month, Day, Year)	32. Régistrar's S	Signature	ATEMA 1						
	Registr	ar	MAR 302	UIU Deneura	/ B. A	arrow						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** March 28. 2010 1845 Anna Mae Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Reeders Memorial Home Washington Boonsboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 ■ F Maryland Sept. 26, 1928 **Director** 217-28-1517 81 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 ■Yes 2 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Completed by Funeral 141 South Main Street 21713 U.S.A11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 1 ☐Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Homemaker nd 2 should be filed vallth and Mental Hygid 27 is marked other r traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George H. Sigler Mary Lapole Sigler Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Hubert R. Smith/ Husband 1520 Monument Road, Middletown, MD 21769 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro Cemetery 03/31/2010 Boonsboro, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Licensee 7606 Old National Pike, Boonsboro, MD 21713 23a. Part 1 E for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive ne year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2/No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Fafter death. 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 29, 20/0 D4499 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Bornshow Mp 217/3 WH-1 MO 31. Date filed (Month Day, Year) State 2010 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27^{Day} Physician/ March 20ÎÖ 2:15 A M Sma11 Howard Ashby Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Hagerstown Washington Sunbrook Lane 8. Date of Birth (Month, Day, Ye Oct • 3, 9. Birthplace (State or Foreign Country) West Virginia Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 - F Hours Director โ′931 232-46-2803 78 Oct. West Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 139 21742 Sunbrook Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Pharmicist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William B. Small Grace Kilmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia F. Small / Wife 139 Sunbrook Lane Hagerstown, Maryland 21742 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 3/30/2010 Hagerstown Maryland 21. Signa are o Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsyt and Death Immediate Cause (Final Pnysician/ mont disease or condition an Medical resulting in death) Due to (c as a consequence of) Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IE EEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 5 1 Yes 2 No 9 Unknown signed by the a d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been sig 1 Yes No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death's within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 D Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Tyes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide determined Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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State

MAR 30 Registrar DHMH 17 Rev 7/2009

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and address of pe

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

(Check

30. Name

only one)

son who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

21740

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22. 2010 Year March Physician/ 4:00 pm Barbara Ann Sutton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11700 Old Columbia Pike, Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 09 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral 1 □ M 2 🛭 F Months Days Hours Min. North Carolina June Director 579-54-4074 67 Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 11700 Old Columbia Pike. U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No 1 Never Married 2 Married ģ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Hygiene. other than "natural", If Yes, Give Year or Dates Specify: African-American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home marked other permit, Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Henry Williams Maru Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 11700 Old Columbia Pike. #113. Silver Spring, MD James H. Sutton - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cem. 04/03/2010 Silver Spring, MD 4 ☐ Departion 5 ☐ Other (Specify) of P eral rvice Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 21. Signi 11800 New Hampshire Ave.. Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Goblet Cell Carcinoid of Ileum disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 X No 9 Unknown the Division of Vital Records, P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should b 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed^a certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 K Residence 6 Other (Specify, 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DQA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be pleted filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M 00059137

State Registrar 1201 Seven Lochs Road, Suite 111, Rockville, Maryland 20854

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Kelly J. Cowen, 31. Date filed (Month, Day, Year) MAR 25

March 23, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 2010 Physician/ Month Eleanor B. Smith 5:30 A M March 24. Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Montgomery Hospice Casey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Social Security Number 6. Sex Days (Month, Day, Year 1 □ M 2 🕱 F Hours Min. Country)
Maryland Months Director 216-12-9249 88 Apr. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-f shorraumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Rockville Maryland 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 Funeral 520 Lawson Way USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🛣 No Yes, Give Maryland 21215-0036 1 🗌 Yes 2🔽 No White Specify: 3 Midowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ellis Howard Barnes Sr. Eleanor LaMar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. Cynthia L. Smith / Daughter 520 Lawson Way, Rockville, MD 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 27, 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. System the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Lung Cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): anding physician use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Year 5 Other (specify) Month Pregnant at time of death 2 😾 No ed by the a detached f Yes P.O. s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 🗌 No 3 🗎 Probably 4 🙀 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed Yes 2 certificate 2 🗌 No 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) Hospice 1 🗌 Yes 2 🔀 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28b. Time of Certificate: 28c. Injury at 1 X Natural work 5 Pending ☐ Accident 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D R120698

Registrar

State

31. Date file

CRNP-F 1355 Piccard Drive, Suite 100, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Nicole Christenson,

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State of Ma	aryland / Depa <i>Cer</i>	artment of H tificate of D			ene .g. No. 201(0 10875
	Physicia	an/	1. Decedent's Name (First, Middle, Last) Adelaide Marian	Salvi			2. Date of Death Month	Day Year	3. Time of Death
	Medic Examin	cal	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	March	22, 2010 4c. County of Deat	12:40 P M
			Suburban Hospital		Bethese			Montgo	
	Funeral Director		1 M 2 F	(In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1 April 7	9. Biri Co.	thplace (State or Foreign untry) PA
ryland	-f show ied at	ctor	10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
he Ma	or 28a e notif	Dire	MD Montgomery 10e. Street and Number	Silver S	pring 10f. Zip Code		10	ng. Citizen of What Co	
with t	is 23a nust be	Funeral Director	15101 Interlachen Drive, U	Jnit 817	20906			USA	
Z1Z13-UU30 within 72 hours after death with the Maryland	tal Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates.	No.	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🏿 No	, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
15-0	n "natur fedical l	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa ind of work done do NOT use retired)	tion uring most of worki	ng 1	6b. Kind of Business	Industry
within	giene. er thai , the N		Elementary/Seconday (0-12) College (1-4 or 5-	+)	Secretary		N	avy Relie	f Society
and be filed	lental Hygier rked other t tic event, th	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
은 등	n and Mental 7 is marked o raumatic eve		Harry Esau 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a		Mendlowi Route Number, C	City or Town, State, Zip	_{o Code)} 20906
			Priscilla Salvi / Daught	er 15101	. Interla	chen Dr.,	Unit 81	7, Silver	Spring, MD
Saltimore bermit. Page 1 a	Department of Healt Important: If item 2 any injury or other i once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Metropoli	natory or other place		n 24,	Oc.Location - City or lexandria,	,
ball	Depart Import any inj once.		21. Signature of Funeral Service Licensee	22 Fr 50	Name and Address cancis J. O Univers	of Facility Collins sity Blvd	Funeral	Home, Inc.	ing, MD 20901
- Phi	sician/	6 11	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final	the death. Do not ente	r the mode of dying	, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
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cate be executed	e attending physician and d for use as the burial-transit	edical Examiner	resulting in death) Last Due to (or as a d	consequence of):					
OS/C ertificat	ding ph e as th		IF FEMALE: 23c. If yes, outcome of	of prognancy					
• box	the state	15	23b. Was decedent pregnant in the past 12 months? 1	2 🗌 Fetal death 3 🔲	Ectopic pregnancy Other (specify)	,		23d. Date of del Month	Day Year
uires that th	igned be de	ed by P	Part II. Other significant conditions contributing to death but	it not resulting in the ur	nderlying cause give	en in Part I.		cco use contribute to	the cause of death?
Kecords, The law requires	n. After this certificate has been s funeral director, page 2 should	Completed			•		24a. Was an autopsy perform	prior to o ed? death?	topsy findings available completion of cause of
VITAII P	ector, p	Be	25. Was case referred to medical examiner?		0.1	ce of Death (Check			
OT VI	er this ceral dir	e: To	1 Inpatie 27. Manner of Death 28a. Date of injury	nt 2 ER/Outpatien 28b. Time of	28c. Injury	4 ∐ Nursing Horat	me 5 Residen 28d. Describe how	ce 6 Other (Special Injury occurred	ify)
ending	death.	Certificate:	1	Year) injury	M 1 □ \	res 2 □ No			
DIVISION tal or Attendir	in by		4 Homicide determined 28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	et, factory, office		28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
he Hospi	within 24 hours a To the Funeral Completed filled	Medical	29a. Certifier (Check only one) 1	amination and/or investi	gation, in my opinior	, death occurred at	the time, date and	place, and due to the o	cause(s) and manner stated.
₽ :	Com com		29b. Signature and title of certifier		29c. License		29	d. Date/signed (Month	ı, Day, Year)
	0		30. Name and address of person who completed cause of de	ath (Item 23a) (Type. Pi		61302		3/23/2010	
			Atul Rohatgi, MD 8600 01d G	Georgetown	Road, Bet	chesda, M	D 20814	11	
	Stat Registra	te ar	31. Date filed (Month, Day, Year) MAR 25 2010 2. Registrar	's Signature	the .				

Please	Type or Print in B	Black Indelible Ink.	Ensure All Copies	Are Legible
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Penny Lee Smith		1- For State Registrar	State of Maryl		oartment o e <i>rtificate o</i>		nd Mental		Reg. No. 20	10 10376
Physicia Medical Exami	in/	Decedent's Name (First, M Penny Lee	liddle,Last) Smith					2. Date of De Month March 29	ath Day Year	3. Time of Death 2030 hrs
		4a. Facility Name (if not instit	tution, give street and r	iumber)		4b. City, Town, o	r Location of D		4c. County of	
		14708 Claude Lane 5. Social Security Number		Tr Ann (to ann	Look high days	Cascade	a littledar 2	Um I Date of E	Washingt	Birthplace (State or Foreign
Funeral Director		171-28-7296	6. Sex	48	. last birthday) Yrs	If Under 1 Year Months Day		Min.	_ ``	Country) Pennsylvania
<u> </u>		Usual Residence of Deceden		100 0	ty, Town or Local				<u> </u>	10d. Inside City Limits
d d		Maryland Wash			gerstow					1 Yes 2 No
Maryland 28a-f show	ecto	10e. Street and Number	iriigroii	l IIa	gerstow	10f. Zip Code	-	1	10g. Citizen of Wha	21
h the N. 3a or 3	٥	14708 Claude	Ave.	_		21719			U.S.A.	
ath wit items 2	Funeral Director	11. Marital Status 1 X Never Married 2	Married Armed I			is Decedent of Hi es, specify Cuba		(Specify Yes or N erto Rican, etc.)	lo- 14. Race - White,	American Indian, Black, etc.
after de	by Fu	3 Widowed 4	1 Yes Divorced If Yes, Give Ye or Dates:	2X No	1 🗆	Yes 2 No	specify:		Specify:	White
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-	(12) College	(1-4 or 5+)		Never Wo	rked		NA	
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2121 ald be f Mental marke	o Be	Paul E. Sm i 19a. Informant's Name/Relati			19b. Mailine	Address (Stre	Patsy et and Number	Rock	ımber, City or Town,	State, Zip Code)
MD 12 shot th and 127 is umatic	-		/ Friend			,		Marylan		,,
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Bal permi Depar Impo injur		21. Signature of Funeral Serv	/ /		16)1 Penns	sorracility P vlvania	Rest Have	n Funeral	Chapel
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√ /Medical √Examiner		Immediate Cause (Final diser or condition resulting in death		tensive a consequence		ascualr	diseas	е		Death
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	iner	if any, leading to immediate cause. Enter Underlying Cause	150	a consequence	of):					
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Box 6876 he death certificate y the attending phy hed for use as the	ician	past 12 months?	4 Preg	birth nant at time of c		tal death 3 ner (Specify)	Ectopic pre	gnancy	Month	Day Year
· ĕ > ĕ	Physician/N	1 Yes 2 No 9 V Part II. Other significant cor	9		resulting in the u	ndorlying cause	given in Part I	23e Did	tobacco use contribu	ite to the cause of death?
Division of Vital Records, P.O. E ral or Attending Physician: The law requires that the d irs after death. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached.	ξ	art ii. Other signmeant cor	antions contributing	to death but not	resulting in the t	inderrying cause	given in raiti.			Probably 4 Unknown
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Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte	01	29a. Certifier 1 Certifying	Physician: To the be	st of my knowle						
To the within To the To the comple	Medical	one) 2 Medical E	xaminer: On the basis and manner	of examination stated.	and/or investigat			ed at the time, date		
	Σ	29b. Signature and title of cer	tifier	10.		29c. Licens			29d. Date signed March 30, 20	(Month, Day, Year)
	-	30. Name and address of pers	son who completed cau	ise of death (Ite	m 23a)					-
		Russell Alexander N	MD. Assistant I	Medical Exa	miner 111	Penn Street,	Baltimore,	MD 21201		
Sta Regist	ate rar	31. Date filed (Month, Day Ye.	0 8 2010 32. R	egstrar's Signa	ture A. A	a the		00	ME	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 1320 M Sullivan William Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNBERLAND ALLEGAN 5. Social Security Numbe Sex 1 M 2 D F . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 9, 1955 Months Davs Hours Country) 212-68-1351 Director 54 MD Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No Hancock MD Washington 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 21750 USA 14461 A Maple Ridge Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black White etc ò δ 1 X Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Disabled should be filed with and Mental Hygien 7 is marked other tt Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Marian R. Dudley Stewart W. Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is P.O. Box 326 Wellsboro, PA 16901 Sharon Sullivan/Sister-n-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State injury or Smithsburg Crematory | 04/05/2010 Smithsburg, MD 4 Donation 5 Other (Specify) 21. nature of Funeral Service Limit 22. Name and Address of Facility 141 West Main Street any rove FUneral Home, P.A.Hancock,MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed the 24 hours after death.

The Eneral Director: After this certificate has been signed by the attending physician and applied filled in by the Inneral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Hospital: 2 1 No 은 1- Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred (Month, Day, Year) 1. Natural injury 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complet only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0

DHMH 17 Rev 7/2009

State Registrar

3 Drivin I Her 1/2

12500 WH HOW Brook Rd, Cum herland,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month Mary Ann Taylor 1:30 P M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 22732 Bellwood Lane California St. Mary's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🖾 F (Month, Day, Year) January 22, Maryland Months Days Hours Min. 72 217-32-4030 **Director** 1938 Usual Residence of Decedent 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits notified at Director 28a-f 1 ☐ Yes 2X No St. Mary's California Maryland 10e. Street and Number 10f. Zip Code ams 23a or r must be r ò 10g. Citizen of What Country? Funeral 22732 Bellwood Lane 20619 USA Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or item fedical Examiner n 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ ☐ Yes 2 🗓 No 1 ☐ Yes 2 X No Specify: If Yes, Give Black Completed 3 X Widowed 4 ☐ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) n and Mental Hygiene. College (1-4 or 5+) Cashier Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic eve ပ John Paul Miles Elizabeth R. Holt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Francis Taylor / Son 22732 Bellwood Lane California, MD 20619 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State i = 10 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Queen of Peace Cemetery March 31, 2010 4 ☐ Donation 5 ☐ Other (Specify) Helen, Maryland Mur of Funeral Service Licensee 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P
P.O. Box 270 Leonardtown, MD 20650 d 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Immediate Cause (Final metastaris with Cancer Gustric Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ylestension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) yeurs physician Hyler Lipidemis Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy perform 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 \square Pending after death. Director: Af 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be I in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled Medical

Division of Vital Records, 24 hours a within 24 hor To the Fune completed fi

Box 68760

P.O.

Baltimore, Maryland 21215-0036

22650 Cedar Lane Court, Leonardtown, MD 20650 Suresh H. Patel, MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) NAR 29 201 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Manth. Dav. Year) 29

10

29c. License number

			For Stata Registrar	State of Ma	aryland		rtment <i>tificate</i>			ind Me		giene 10g. No.	010	108	379
			1. Decedent's Name (First, Middle, Las	t)						2	. Date of Dea Month	ith Day	Yeer	3. Time o	of Death
	Physicial // Ph		Harold Lee THOMA	S						M			2010	8:50	ам
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, T	own, or	Location o	f Death		4c.	County of De	ath	
			Julia Manor Nurs	ing Home					stown			W	ashing		
	Funeral		Social Security Number 6. Security Number	ox 7. Ag	e (In yrs. la			Year Days	If Under 2 Hours	Min.	. Date of Birth (Month, Day	r, Year)		irthplace (State Country)	or Foreign
ш	Director		219-12-1430	MM ZUF	86	Yrs.					Jan. 1	9 19	24 M	aryland	
	pu >	-	Usuel Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation							10d. Inside (City Limits
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	8a-1	Sct	Maryland Washing	ton		Hage	rstow					10- 04	zen of What (1	
	ith ti	吉	10e. Street and Number				10f. Zip (İ	rog. Citiz		Jountry?	
	ath v	by Funeral Director	10919 Clinton Ave						740	1-0 (0			USA	nerican Indian,	
	er de	nue	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decede f Yes, speci	fy Cuba	n, Mexican	, Puerto Ri	fy Yes or No- can, etc.)		Black, Wh		
36	s afte	Ϋ́F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 ! If Yes, Give Year or Dates:	No		1 ☐ Yes 2	X No	Specify:				Specify:	White	
21215-0036	72 hours after death with the Maryland natural', or Items 23e or 28e-f ehow issal Examiran must be rediffed at	å d	15. Decedent's Ed			16a Decer	dent's Usual	Occups	ation			16h Kir	nd of Busines	s/Industry	
15	"na"	Completed	(Specify only highest gra	de completed)		(Give	kind of work	done o	during most	of working		100. 10	IG OF DUSITIOS	a moustry	
12	within ene. then "	E .	Elementary/Secondary (0-12) 7	College (1-4or 5		Sheet						Δi	rcraft	Mfo	
9	Hygin ther		17. Father's Name (First, Middle, Last)		1.	DIECE	IIC Car	WO.		r's Name (First, Middle,				
au	ould be to Mental I Marked of Marked of	Be	Harry E. Thomas					İ	Fann	ie Sm	ith				
Maryland	s i and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene the fam 23a or 28a-1 show itam 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Examinar must be rediffied at	ပ	19a. Informant's Name/Relationship	Tyne Print)		19b Mailir	na Address	(Street a				r. City or	r Town, State	Zip Code)	
Ma	d 2 s th an														
	of Health itam 27 other tr	ŀ	Bertha I. Thomas 20a. Method of Disposition	- wire	20b. Pla	ace of Dispo	sition (Nam	e of		nue,			, Md.	r Town, State	
ŏ	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐		Cei	metery, crer	natory or oth	her plac	1	10011					
Ë	tant tant		4 Donation 5 Other (Specify		Ced	ar Lav								, Mary	Land
Baltimore,	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licen	see n	. ()								al Hom		
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1	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ne				_			1651,		Onset and	etween
8760,	eate be executed hysicien and the burlal-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.											
P.O. Box 68	The law requires thet the death centificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a' 9 □ Unknown	2 Fetel	death 3[Ectopic pre					2	23d. Date of o	lelivery Day	Year
Records, P	uires thet signed b Id be deta	þ	Part II. Other significant conditions of	mad.			nderlying ca	iuse givi	en in Part I.				se contribute □No 3 💢	to the cause of Probably 4	death?]Unknown
Ö	w require been si should t	Completed	2 d -10	elese n	201	,					24a. Was	an	24b Were	autopsy finding	s available
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Vital	icier certif recto	Be	25. Was case referred to medical examiner?	Hospital:				Oth	or .		Check only o				
of	Phys this aldii	- To	1 Yes 2 No 27. Manner of Death	1 🗆 Inpatii		R/Outpatier 28b. Time o		M	4 LANU		e 5 ☐ Resid Id. Describe h		6 Other (S)	oecify)	
L C	ling After	o	1 Satural 5 Pending	28a. Date of Inju (Month, Da	y Year)	Injury	M	Bc. Injur	k? Yes 2 🔲		d. Describe i	iow injui	y occurred		
Division of	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not b	e One Diese of le	ium. At hor				163 2 🗆		If Location /	Stroot an	d Number or	Rural Route Nu	mhar
Ξ	or A	ıtı	4 Homicide determined	building, ei	tc. (Specify,	me, rarm, sti	reet, factory,	, orrice		20	City or Tov			HUIZI HODIÐ IVE	111061,
	urs a		X										<u>-</u>		
	To the Hospitel or Attending Physicien: The lave within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Exar	niner: On the best	of examinati	ion and/or in	vestigation,	in my o	pinion, dea	th occurred	d at the time,	date and	place, and d	ue to the cause	(s)
	the the Tplet	Med	one)	and manner st	ated.		200	Licens	e number			29d Dat	te signed /Ma	nth Day Year	
	产素的	-	250. Signature and title of certifier	1		/	290.	1 1 2	1:00	6		5 A A	~!/)	6) Lil	0
	OX+>		7	1	//		- 1	7	477			IV) G	ich	, 201	
_	6		30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of	death (Hem	23а) Туре,	311/6	M	ans	Rd	Boon	sher	U MD	217/3	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 29 20	32 Aegist	rar's Signat	1. A.	arked								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ William Wilkinson Eugene <u>3:</u>45^{A™} March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown St. Mary's Hospital Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Months Hours Country) D**i**st**r**ict 75 Yrs. Director 579-48-9266 of Columbia 16,1934 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Mechanicsville 1 ☐ Yes 2 X No Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20659 39588 Mason Drive USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "na any injury or other traumatic event the proce. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Technician Verizon Communications 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cecelia William Wilkinson Sr. Ruth Eugene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39588 Mason Drive, Mechanicsville, MD 20659 19a. Informant's Name/Relationship (Type, Print) Sylvia Wilkinson / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State March 30, 2010 Leonardtown, Maryland Charles Memorial Gardens 4 Donation 5 Other (Specify) 21 Signature of Funeral Service Acepse 22. Name and Address of Facility Mattingely-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Minutes cedino Medical resulting in death) The to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law region.

Within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and the Funeral Director. After this certificate has been signed by the attending physician and the Funeral Director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes

State Registrar 2 X No

5 Pending

Investigation

determined

6 Could not be

27. Manner of Death

Natural

3 ☐ Suicide 4 ☐ Homicide

only one

31. Date filed (Month

29b. Signature and title of certifier

Jutthe

29a. Certifier (Check

30. Name and

Accident

Certificate:

Medical

ER/Outpatient 3 DOA

O. Box

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

work? 1 Yes 2 No

29c, License number

524

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 X

(Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

28a. Date of injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

WU

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

20650

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month March 26, 2010 3:50 p <u> Lillian Louise Weller</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Reeders Memorial Home Boonsboro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) Date of Birth (Month, Day, Birtinplace (State or Foreign Country) Year Days 1 □ M 2 😾 F 93 Maryland January 219-14-9322 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 42 Manor Drive 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 □ No Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Executive Secretary Airplane Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martin Luther Weller Sr. Bertha May Stattler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 953 W. Washington St. Hagerstown, MD 21740 Martin L. Weller, Jr./ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematorium 3/28/2010 Smithsburg, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocaydial Due to (or as a consequence of le Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) her Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to de ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performe 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident

Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician Division of Vital Records, P.O. Box 68760.

Physician /Medical

> signed by has After after death Director;

Physician

/Medical

Examiner

Funeral

Director

28a-f show

"natural", or items 23a or

Director

Funeral

2

Completed

Be

2

Examine

Physician/Medical

2

Completed

Be

Certification: To

Medical

death with the Maryland

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other traumetr.

21215-0036

Maryland

Baltimore,

O

3 Suicide

29a, Certifier

4 ☐ Homicide

(Check only

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

6 ☐ Could not be

29c. License number 44996 29d. Date signed (Month, Day, Year) March 26, 20/0.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zafar Malik 20311 Lappans Rd. Boonsboro MD 21713

and manner stated

31. Date filed (Month, Day, Year) MAR 30 32. Registrar's Signature

State Registrar

e Funeral I

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician LIMOTHYA. WILLIAMS 7:20 March 21 2010 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 XM 2 ☐ F Months Days Hours 577-60-9720 64 DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, I've Medical Examiner must be notified at Director 1XIYes 2 □ No Hyattsville Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6135 Osborn Road 20785 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Black Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Storekeeper Government marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F Be should be Helen L. Hawkins Clarence E. Williams ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health ar 6135 Osborn Road Hyattsville, Maryland 20785 Daisy R. Williams/ Wife Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Maryland Veterans 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) State Cemetery 21. Signature of Funeral Servick Lice. 22. Name and Address of Facility Stewart Funeral Home, Inc. my 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) ned by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign Atherosclerotic Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown s been si Coronary Artery Disease, Hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 Physician: The certificate Peripheral Arterial Disease 1 ☐ Yes 2 🖾 No After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A pletely filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and tit of 29c. License number D 48213 March 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neelam Ashai MD 4410 74th Avenue Land 20784 Landover Hills, Maryland 32. Register's Signature 31. Date filed (Month, Day, Year) State MAR 2 6 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 23, 2010 **Physician** Jean Melvinette West 4:16 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hospital Cheverly Prince George's 8. Date of Birth (Month, Day, Year 8/30/1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 😾 F Months Days 579-52-7470 84 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Marical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Prince George's Upper Marlboro 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code 13909 New Acadia Lane United States Funeral 20774 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No 2 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin E. Briscoe Irene E. Chapman ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila B. Ray (Sister 10708 Lake Arbor Way Mitchellville, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery 3/30/2010 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses Luht theo -3401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a gorsequence off Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 \(\subseteq \text{Ectopic pregnancy} \) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 FER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director: A
bletely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State Registrar 29b. Signature and

AMIE 31. Date filed (Month, Day, Year) MAR 2. 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D67628

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For	State	of Maryland		rtment of H		Mental Hy	giene		
		_1	State Registrar	141		Cer	tificate of D	eath	2. Date of Dea	Reg. No. 2	10	3 Time of Beat
	Physiciar		Decedent's Name (First, Middle Helen Lee Was						Month March	22, 20)10 Year	3:30 P. M
·~.	Medic	al _	a. Facility Name (if not institution		nber)		4h. City. Town, or	Location of Death		4c. County		
	Examine	er '	Suburban Hos				Bethes				ntgome	
	Funeral		. Social Security Number	6. Sex	7, Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h v. Ye <i>ar</i>)_	9. Birthp Count	lace (State or Foreign ry) D.C.
В	Director	Į	577-22-2599	1 □ M 2 X F	91	Yrs.	WOTERIS Baye		02/16/	1919	Wash	.,D.C.
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	or 28	ă	10e. Street and Number				10f. Zip Code			10g. Citizen of		
	be filed within 72 hours after death with the Maryland ental Hygiene. Wed other than "natural", or items 23a or 28a-f show ked other than "natural", or items 21a or 28a-f show ite event, the Medical Examiner must be notified at	Funeral Director	# 15 41st St	,N.E. #	104		200				U.S.	
	items items		11. Marital Status	Armed Fo	edent Ever in U.S orces?	S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americ ick, White,	etc.
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21215-0036	atura cal E	ete	15. Deced	ent's Education		16a. Deced	dent's Usual Occup	ation	rking	16b. Kind of E		
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pu	ital Hy ed oth even	To Be	17. Father's Name (First, Middle, George Wils					Annie		Walden Suman	10)	
Maryland	g should be filed within 72 h and Mental Hygiene. 7 is marked other than ", traumatic event, <u>the Mec</u>		19a. Informant's Name/Relation			19h Maili	ng Address (Street			er, City or Town,	State, Zip (Code)
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	ge 1 and 2 should be it of Health and Men if item 27 is marke or other traumatic		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place		Date	20c. Location		own, State
JO L	age 1 ent of nt: If i		1 🔀 Burial 2 □ Crematio 4 □ Donation 5 □ Other			Olive		03,	/27/10	Washi	ngton	,D.C.
। Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Funeral Service		rall	2	2. Name and Addre Henry 925 Burro	S. Wash:	ington &	Sons C	o.,In	c. .c.20019
2	40 = 60		22a Part 1 Enter the dise ve	or complications that	t caused the deat							Approximate Interval Between
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2 %	physic physic the b	edic		d								
(ACC)	pertifica nding phase as the	M/u	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, o	utcome of pregn	ancy	Ectopic pregnar	OCV.			Date of deliv	
Š×Š Bo׊	requires that the death certifical been signed by the attending ph should be detached for use as th	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No		egnant at time of		Other (specify)			'	Vionth	Day Year
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2 2	sician: The law r certificate has b lirector, page 2 s	Be C	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpati	ent 3 DOA Ot	her: 4 \(\sum \) Nursing	Home 5 Res	sidence 6 🗆 C	ther (Speci	fy)
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	r Atte ter de irecto	Certificate:		28e. Pla	ace of Injury - At I ilding, etc. <i>(Speci</i>	home, farm, s ify)	treet, factory, office	9	28f. Location City or To	(Street and Nur own, State)	nber or Hur	al Route Number,
Washington Hele	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.		an outies 1 Contibu	ing Physician: To the	e hest of my know	wledge death	occured at the tim	ne, date and place	, and due to the	cause(s) and ma	nner as sta	ted.
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>	Го the vithin Го the хотпрІ	Σ	29b. Signature and title of cert				29c. Licer	se number		29d. Date sig	ned (Month	, Day, Year)
	->-		Doselo	Donnos	- MM)	DC	062999		March	23,20	010
an	j		30. Name and address of pers	on who completed c	ause of death (Ite	em 23a) (Type	, Print)					
UL			Petek Donmez		D 11 1 0:		sional Pa	rk,Rockv	ille,Mar	yland	20852	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year MAR 2 6 201)		2. Registrar's Sign	Jake						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend 869 per FH G902 4/8/10 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ KASH Medical County of Death Washington 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown County Hospital Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year, 9/26/1920) Min. Maryland 1**X**☐ M 2 ☐ F Hours 89 Director 213-12-7432 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Washington Hagerstown 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21742 U.S.A. 914 West Irvin Avenue 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or lany injury or other traumatic event, the Maximum once. 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify: White 3 Widowed 4 Divorced WW II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Parts Salesman 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Stauffer Walker Sr. Helen Josephine Randolph John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 914 West Irvin Avenue, hagerstown, Maryland 21742 Mary June Walker Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) |Hagerstown Crematory | 04-05-10 Hagerstown, Maryland Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Signature of Funeral Service Licenses R. hoel Md. 21742 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, an each line. Approximate 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Interval Between On Property Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine to (or as a conseque led by the attending physician and detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Unknown Unknown P.O. I ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No this certificate within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No Certificate: To 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ann f Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29a. Certifier

29b. Signatu

(Check

only one

30. Name and address of per

DHMH 17 Rev 7/2009

2/

n who completed cause of death (Item 23a) (Typ

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month April Year 2010 1:10 PM Nancy Elizabeth Allan 7 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care 8. Date of Birth (Month, Day, Year) Towson Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Min Months 62 Maryland **Director** Yrs 218-48-6207 1947 Usual Residence of Decedent 10a. State 10b. County Ħ 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits r 28a-f sl notified Harford 1 Yes 2 No Aberdeen 10e, Street and Number ö 10f. Zip Code 10q. Citizen of What Country? iral", or items 23a o Examiner must be Funeral 1365 Tralee Cir 21001 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural" 3 Widowed 4 Divorced Specify Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dental Health Care Office Manager and Mental Hygie is marked other permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dwight Chester Rowell Helene Margaret Waller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Allan /Son 1365 Tralee Cir Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Apr 09 2010 Beltsville, Maryland Chesapeake Crematory ature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death the Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 3

☐ Probably 4 ☐ Unknown Division of Vital Records. 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? certificate 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this in 24 hours after ueau... he Funeral Director: After th unleted filled in by the funeral 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide work? 5 \square Pending iniury Investigation 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 29b. Signature and title of certifier Durw

State

Registrar

31. Date filed (Mor

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egistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician Steve Augerinos 8:30 AM APRIL 2040 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGMES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. Aug 15, 9. Birthplace (State or Foreign $\mathbf{P}\mathbf{\hat{A}}^{ountry)}$ 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Months 1 M 2 □ F 217.26.3480 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md 1 ☐ Yes 2 ▼No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6201 Lakemont Court. 21228 USA by Funeral 12. Was Decedent Ever in U.S. Awned Forces? 1 APYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fiscal Comptroller Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Augerinos Diane Calajose ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6201 Lakemont Court. Catonsville, Md 21228 19a. Informant's Name/Relationship (Type. Print) Norma Augerinos Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington Nat'l Ceme 20a. Method of Disposition 20c. Location - City or Town, State 5/6/2010Burial 2 Cremation 3 Removal from State Arlington, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility terling Ashton Schwab Witzke Funera 21. Signature of Funeral Service License Home of Catonsville, Inc. 1630 Edmondson Ave. 23a. Par 1. Enter the disease, or applications that cause the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List hely one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CHRONIC HEART FATLURE 1 year /Medical Due to (or as a consequence of): Examiner Week PLEURAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be execut cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar P.O. Box 68760,5 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed: 2 Z No 1 ☐Yes 2 ZNo 1 ☐ Yes Hospital or Attending Physician; 24 hours after death. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Registrar DHMH 17 Rev 1/2001

State

1041

29b. Signature and title of certifier

900

31. Date filed (Month, Day, Year)

MID

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

BALTIMORE

P24062

ALWAFAA KHATIB

29d. Date signed (Month, Day, Year)

3,2010

10888

		•	amend #17 Pestate of Warytand / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death Month of Pay	Year 3. Time of Death
	Physicia /Medic	al		8/2010 5:00AM
8	Examin	_	ter 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location or Death	. County of Deeth
			5 Save Saverity Number 6 Sav 7 Age (In vrs. last hinthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign
\$**	Funeral Director		5. Social Security Number 6. Sex / Age III yis. last billious/ Months Days Hours Min. (Month, Day, Year)	Country)
	land ow	-	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Mary I sh	ţō	Washington, D.C.	1 ☐ Yes 2月 No
	be ilied within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or items 23a or 28a-1 show event, the Metical Examinat must be notified at event, the Metical Examinat must be notified at	Il Director	10e. Street and Number 10f. Zip Code 10g. Cit 2 1 53RD Place S. E. 20019	tizen of What Country?
	death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
920	ours after	by	3 Widowed 4 Divorced Year or Dates:	Specify: BLACK
2-0	72 hc	etec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. K	(ind of Business/Industry
Maryland 21215-0036	e filed within at Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Laundry Worker Hu	48 Laundry
	be filed ital Hygie d other	Be	17. Father's Name (First, Middle, Last) John Henry Boyd	nes
yla	should be ind Mental is marked (umatic ev	၉	P 30H HOLL WOOTE	
Mar	a a a	1 3	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Hural House Number, City of GorrySteen Anchrews/daughter 21 53RD Place SE, Mas	3H. 1/C.20019
	f Health item 27 other tr	1 3	20a Mathod of Disposition 20b. Place of Disposition (Name of Date 20c. L	ocation - City or Town, State
Jor	Pages nent of I int: if its iry or o	1 1	CAMPIERV CRAMATORY OF OTHER DIACEL	itland, mD
Baltimore,			1 Tours (1) 1 Tour	YZOH ST. NE.
Ba	permit. Departr Imports any inju		Risa a. Henry mours B.K. HEnry Funeral Home	WasH.DC-20002
			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
	Physician		Immediate Cause (Final Tand Stage Drawit notice	Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	CIR STILL
П	Examiner		Sequentially list conditions, b. SP RECENT PNEW MONIA	
	₽ #	ner	o if any, leading to immediate Due to (or as a consequence or):	21/20/20
	cate be executed physicien and the burial-transit	Examin	Cause (Disease or injury that initiated events required that initiated events required that initiated events required that initiated events required to (or as a consequence of):	CHronic
50,	oe exection s	E C	Bue to (or as a consequence of).	
8760,	physii	dical	0	
3. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
P.0	that the de ed by the detached			use contribute to the cause of death?
Records,	w requires that been signed I should be det	ted by	1 TVas	2 No 3 ☐ Probably 4 ☐ Unknown
Reco	The law rate has be page 2 sh	Completed	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital		Be C	u 25. Was case referred to medical 26. Place of Death Check on one	
>	S S S	မ	1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence	
D C	ding P. J. After ti funera	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Work? A M 1 Yes 20 No	ury occurred
Division of	To the Hospital or Attending Phwithin 24 hours after death. To the Funetal Director: After the completely filled in by the funeral	Certification:	2 Accident 3 Suicide 4 Homicide 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Location (Street a City or Town, Sta	and Number or Rural Route Number, tte)
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(2 Medical Examiner: On the basis of exampliation and/or investigation, in my opinion, death occurred at the time, date and manner stated	s) and manner as stated. nd place, and due to the cause(s)
	o the ithin (o the omple	Mec		Date signed (Month, Day, Year)
	F % F 8		R 150892 4	1/5/2010
1	V		30. Name and address o person o completed cause of death em 23a) (Type, Print) Van Chew NP 9241Sfluart Lane Clinton, MD 2 ate 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4 pp 19 2010 4 parks	20735
	St	ate	ate 31. Date filed (Month, Day, Year) 32. Rejistrar's Signature	
	Regist	rar	trar ADD 0 9 2010 Levery S. James	
-			PRI ET W W TO THE P	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year JOANN AYERS 1 : HAM 2010 VIA 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foleigr Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year) Days 1 □ M 2**X** F Sept 1, Maryland **2**17-32-7535 74 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County Baltimore n/a 1 XYes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 U.S.A. 1534 William Street 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 __No 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2K No If Yes, Give Year or Dates: Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) machine operator envelope production 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alvera Taylor John Boland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Wolf daughter 8205 Northview Rd. Dundalk, Maryland 21222 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery April 12, 2010 | Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. ervice Licensee WWW 237 E. Patapsco Ave. Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): 5 days TRACT URINARY INFECTION Sequentially list conditions, if any, leading to influedate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) PNEUMONIA Due to (or as a consequence of) MYOCARDIAL TNIFARCTION If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed

Physician /Medical Examiner

attending physician and for use as the burial-trar

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macinal Examinat must be notified at

Baltimore, Maryland 21215-0036

Examiner Physician/Medical signed by to þ Completed Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed

has been

certificate

After this

ours after death.

leral Director: #

filled in by the for

within 24 hours a

To the Funeral C

Medical

State Registrar

Division of Vital Records, P.O. Box 68760,

l	
	IF FEMALE:
ı	23b. Was decedent pregnant in the past 12 months?
	1 ☐ Yes 2 💢 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death?

2 No

1 ☐ Yes

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2. No

27. Manner of Death 1 Natural 5 Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE, MD

28d. Describe how injury occurred

1 □Yes

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

29b. Signature and title of certifier Insan Species

29c. License number RES DOI 29d. Date signed (Month, Day, Year) APRIL, 8,2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANDVER STREET,

JUSAN GEORGE 31. Date filed (Month, Day, Year)

32. Registrar's Signature



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 3:45 PM Benjamin F. Bennett 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Mayland Medical Cente Baltimore If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 X M 2 🗆 F Hours M2th, P3 ^{Ye}1 952 Country) 215-58-3985 57 Director D.C. Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD White Marsh 1 🗆 Yes 2 🏝 No Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21162 11165 Philadelphia S Α 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc.
White Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married Completed by 1 Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+)

3 vea Disabled 12th grade years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norma Nichols Benjamin F. Bennett, permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Daisy Road Burkley Heights N.J. 09922 Amy Bennett-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremention 3 ☐ Rem 4-7-2010 Baltimore, Md Greenmount 4 Donation 5 ther (Specify) East F/H 21. Signature of Fun val Service Lic 22. Name and Address of Facility March Balto, MD 21202 E. North Avenue 1101 23a. Part 1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each line that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final irrhosis Priysician disease or condition resulting in death) 10 years Medical Due to (or as a consequence of) Examiner oneumonia 2 Weeks Sequentially list conditions. if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an nis certificate has b I director, page 2 sh autopsy perform Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No After this c 2 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 6,2010

10

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month. Day.

Everne St. Baltimore, MD 2120

completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

22 5.

MD

Baltimore, MD 21215-0036 Permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Pepariment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1- For State Registrar 1. Decedent's Name (First, Mi	Patric tition, give street and number et	Certific	rs, Sr 4b.C	eath	2. Date of I Month April 6,	Reg. No. Death Day 2010	Year Inty of Death	3. Time of Death 1145 hrs
Medical Examiner Funeral Director	Decedent's Name (First, Mi 4a. Facility Name (if not institution 1606 E. Chase Stre 5. Social Security Number 216-78-3795 Usual Residence of Decedent	Patric tition, give street and number et	k Bye	rs, Sr 4b.C Ba	ity, Town, or Location	Month April 6,	Death Day 2010		1145 hrs
Medical Examiner Funeral Director	4a. Facility Name (if not institu 1606 E. Chase Stre 5. Social Security Number 216-78-3795 Usual Residence of Decedent	Patric tition, give street and number et	r)	4b. C Ba	ity, Town, or Location	Month April 6,	2010 Day		1145 hrs
Director	1606 E. Chase Stre 5. Social Security Number 216-78-3795 Usual Residence of Decedent	et 6. Sex 7. A		Ва		of Death	40. 000	illy of Death	
Director	216-78-3795 Usual Residence of Decedent	1 M 2 F	ge (In yrs, last bi						
the Maryland s or 28s-f show any tiffed at once.			50		Under 1 Year If Und onths Days Hour		f Birth(MM/DD/Y -13-195	Foreig	
the Maryland a or 28a-f show itified at once. Director			10c. City, Towr	n or Location					10d. Inside City Limit
the Maryl	MD	na	Balt	imore					1x Yes 2 N
	10e. Street and Number 1606 E. Cha	ase Street		10f	Zip Code 21213		10g. Citizen o		itry?
er death with t	11. Marital Status 1 XXNever Married 2	Married 12. Was Deceder Armed Forces 1 Yes			cedent of Hispanic On pecify Cuban, Mexicar			Race - Ameri Vhite, etc.	can Indian, Black,
s after or all, o	e	Divorced If Yes, Give Year or Dates:			2XX No specify		Spec	of Business/I	lack
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exan Completed	15. Decedent's Education (S Elementary/Secondary (0-1			during most of	sual Occupation (Give f working life, DO NO?	ruse retired)	lob. Kind C	n business/i	na na
0036 within giene. Medic	12th grade 17. Father's Name (First, Midd	tie Last)	na	J	Jnemploye 18 Mothe	ed or's Name (First, Midd	lle Maiden Sum	ame)	
1215- d be filed lental Hyg arked oth went, the	Clifton By	ers	146	Oh Mailing Add		adeeline	Kane		Zin Codo)
MD 21 d 2 should Ith and Me n 27 is ma tumatic ev	Edna K. Ai		int	1532 N	Medford F	Road Bal	to,MD	21218	i
more, ages l an ent of Hea nt: If iten	20a. Method of Disposition 1 K Burial 2 Cremat 4 Donation 5 Other		u crema	of Disposition atory or other pl Calvai	(Name of cemetery, lace) CY Cem	Date 4-10-20	1	ion - City or nBurn	
Baltir permit. I Departme Importan	21. Signature of Fundal Serv		\$		and Address of Facili			/H Ea	
Physician	23a. Pärt I. Enter the disease, failure. List only one cau	se on each line.		not enter the mo					Approximate Intervi Between Onset and Death
Examiner	Immediate Cause (Final disea or condition resulting in death			cnest					
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.		sequence of):						
	(Disease or injury that initiate events resulting in death) Las		sequence of):		-				
be execu sician an urial - tr	UNPENDED	AMENDED					17/4/11		
on of Vital Records, P.O. Box 68760, anding Physician: The law requires that the death certificate be executed ath. I. After this certificate has been signed by the attending physician and he funeral director, page 2 should be detached for use as the burial - transit tion: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	1 Live birth	at time of death	2 Fetal de	eath 3 Ectop	ic pregnancy	23d. Da Mon	te of delivery th E	/ Day Year
P.O. Bost that the degree by the edetached for by Phy			ath but not resulting	ng in the under	lying cause given in P	p	yid tobacco use o	_	the cause of death?
on of Vital Records, P.O. anding Physician: The law requires that thath. rr. After this certificate has been signed by he funeral director, page 2 should be detachtion: To Be Completed by P				·		a	Vas an 2 utopsy erformed? es 2 ✓ No		topsy findings availab completion of cause of
ital Resident The secutificate inector, page Co	examiner?		ient 2 ER/0	Outpatient 3		(Check only one) Nursing Home 5			
on of Vi ending Physi ath. or: After this he funeral dir tion: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of In (Month Day Apr 6, 2010	iury 28b.	. Time of Injury			ibe how injury or		

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Division
To the Hospital or Attent within 24 hours after death
To the Funeral Director: completely filled in by the

28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide 6 Could not be or Town, State) 1606 E. Chase Street, Baltimore, MD determined (Specify) Rowhouse Homicide 29a. Certifier (Check only one)

29a. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 7, 2010 O.C.M.E. OGME 111

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD.

Registrar's Signature

31. Date filed (Month, Day, Year) State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar amend 10bc, 19b per f.h. goodfiisate9910eath Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 0400 AM Qyntin Lamar Bond Apri. 3 2010 /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 4 - 2 - 2010 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 2^{Min.} Months Hours 14 1**X** M 2 ☐ F N/A 0 Maryland Director Usual Residence of Decedent death with the Maryland 10b. County Howard 10d. Inside City Limits 10a State 10c. City. Town or Location Pages 1 end 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
and: If item 27 ie marked other then "natural", or iteme 23e or 28e-f ehow this the the trainfield the trainfield the confiled at my or other treumatic event, the Modical Examination the notifield at **Elkridge** Clon Burnie 1 Yes 2X No Anne Arundel Director 21075 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 USA 6330 Washington Blvd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 Tyes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Berry Hedwarda Bond ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Furker Filing Town, 2407) Sode) 6330 Washington Blvd Clen Burnie, MD 21061 Hedwarda Bond 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Depertment o Important: If eny injury or once. Bayview Crematory 4-8-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityKaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Insufficiency 15 hours /Medical Due to (or as a consequence of): Examiner Extreme Premoturity hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires thet the death certificate be executed burial-transit Sepsis 15 hours and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physician for use as the buria Respiratory Distress Syndrome Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by certificate has been signi rector, page 2 should be Adrenal Insufficiency 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes the Hospital or Attending Physicien: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 1 ☐ Yes 2 No Other: 4 \(\text{\text{Nursing Home}}\) 5 \(\text{\text{Residence}}\) 6 \(\text{\text{Other}}\) Other (Specify) မှ 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After Injury 5 Pending investigation death. 1 Yes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗀 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated Within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ပ nine Bullend, MD April 3, 2010 DO060862 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD 21224 Janine Bullard, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 09 Server Registrar

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			Please	Type or Print in					and the same of th	1 100	10001	
			For State	State of Marylar	ryland / Department of Health and M Certificate of Death							
			Registrar 1. Decedent's Name (First, Middle, Las	t)	Certin	Jale Of D	catri	2. Date of De			3. Time of Death	
Physician/ Medical			Anthony Brac	1129				Month 4	C Day	7010 Year	31,55P M	
	Examir	ner	4a. Facility Name (if not institution, give	street and number)	4b. City, Town, or Location of Death			4c. County of Deat				
	Funeral		5. Social Security Number 6. Se	fast birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birt Yrs. Months Days Hours Min. (Month, Day				th Year)	9. Birthplace (State or Foreign			
	Director		218-60-3322 1 M 2 F 56 Yrs. Months Days Hours Min.						5,195		ryland	
	with the Maryland 23a or 28a-f show ist be notified at	tor	10a. State 10b. County	ty, Town or Location	or Location					10d. Inside City Limits		
		Director	Ma. No	Baltin	Baltimore 10f. Zip Code				10g. Citizen of What Cour			
		eral [10e. Street and Number	um Rd			07		10g. Citize	en of What Cou	untry?	
	items	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was I	Decedent of Hisp specify Cuban.	panic Origin? (Sp Mexican, Puerto	pecify Yes or No-	14	4. Race - Amer		
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates.	1 ☐ Yes 2 🕅 No Specify:				Sį	Black, White, etc. Specify: Rack		
21215-0036		To Be Completed	15. Decedent's Ec (Specify only highest gra	ducation	16a. Decedent's	Usual Occupat	ion ring most of wor	kina	16b. Kind	d of Business I	ndustry	
121			Elementary/Seconday (0-12)	College (1-4 or 5+)		T use retired)	a d	King		1/12	ı.	
			17. Father's Name (First, Middle, Last)		1 VI	SUBI	18. Mother's Nar	ne (First, Middle,	Maiden Su	ırname)		
Maryland			Leroy Nathai	Bradle	24		Eliz	abet	<u> </u>	Mars	háll	
Mar			19a. Informant's Name/Relationship (Ty	pe, Print) (Brother)	19b. Mailing Ad	dress (Street an	d Number or Ru	ral Route Numbe	r, City or To	own, State, Zip	Code) イノケック	
			20a. Method of Disposition		Place of Disposition cemetery, cremator		ey 31	Date Date	20c. Loca	ation - City or T	own, State	
Baltimore,			1 M Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Heliloval Ilolii State	14 Memo	rial Pa	CK 4/12	2/2010	Ray	ndall:	stown, Md	
Ball			21. Signature of Funeral Service Licens	Fra	22. Nar Jo S	ne and Address	of Facility	uneral	How	ie.P.A.	/	
1			23a. Part 1. Enterune disease, or comp	lications that caused the deat	th. Do not enter the	mode of dying,	such as cardiac	or respiratory ar	rest,	M'a . 7	Approximate	
	nysician,									Interval Between Onset and Death		
and the same	E 25		resulting in death) Due to (or as a consequence of):									
			Sequentially list conditions, if any, leading to immediate	b. Due to (cr' do a consequ	čorišcijdisničs dij:							
		Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events									
		اجا	resulting in death) Last	, ,	to (or as a consequence of):							
Box 68760		Medi	IF FEMALE:	d								
9 X		ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			23d. Date o		d. Date of deli	very Day Year		
. B		Physician/Medic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown				WORR			Day 16ai		
Division of Vital Records, P.O.		by P	Part II. Other significant conditions co	ntributing to death but not res	outing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death?				
rds,	equire seen si hould b	eted							1 Yes 2 No 3 Probably 4 M Unknown			
eco	e has t ge 2 s	Completed by					autopsy prior to co			opsy findings available ompletion of cause of		
al H	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Euneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Be C	25. Was case referred to medical examiner?	1 ☐ Yes 2 12 No 26. Place of Death (Check only one)						1 🗆 Yes	2 🗆 No	
f Ši		Medical Certificate: To E	1 Yes 2 No	lospital: 1 Inpatient 2			ome 5 - Residence 6 Vother specificent huspin					
o uc			1 Matural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work?					. Describe how injury occurred			
visio			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e l				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ö			29a, Certifier 1 Certifying Phys	ledge, death occur					manner as stat	Pd		
			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							ause(s) and manner stated		
			29b. Signature and title of certifier 15 Right plan 2M.D.			29c. License number D 005 7 46 5			29d. Date signed (Month, Da 4 7 / 10			
			Y I I					-				
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. S. Rajapakse M.D. 2835 Smith Av., S-203, Baltimore, MD 21209 31. Date filed (Month, APRa) 9 2010 32. Registrar's Signature								21209	
	Stat Registra	ie ar	APR ^a 0 9 2	010 Seneus	ture I. Sa	Mad						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month: **Physician** Drown 4:38P April 2010 onias /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner haltmore Johns Hopkins 6 10601tal If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) (In yrs. last birthday)

63 Yrs. 8. Date of Birth (Month, Day, 5. Social Security Number 1946 **Funeral** Months Days 1 1 M 2 □ F Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director altimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number , or items 23a or Midwood 21212 60 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces?
1 □ Yes 2 □ No 1 Nes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Black þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Çode) ant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 1 id wood Brown-Alle 21212 20b. Place of Disposition (Name of cemetery crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 Removal from State anei 4 Donation 5 Other (Specify) 21. Signature of Funeral Service L Batto-MD2007 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed ending physician and use as the burial-transit pertension resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) TYes 2 No 9 Unknown as been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records. ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s certificate has autopsy 2 🗆 No 2 X No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No r this r 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Il Director: A death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certify 400630 address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month,

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Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2abeth April jarter 9:00 AM 2010 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director Feb 1 marylano Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🗷 No Director MD Itimore 10g. Citizen of What Country 10e. Street and Number Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 In It Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📝 No þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15 Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Luke 12 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Blake Elizabeth Jr. rstield 19a. Informant's Name/Relationship (Type. Print) - Father 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) bradford E Baltimore MD 16 Elmwood Rd 21210 20b. Place of Disposition (Name of cemetery, crematory or other place)

Exans Funeral Chape

and Crematics Services 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Forest Hill, Mayland 19/2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility hapel & Cremation Services-Partuille 8800 Harford Rd mo 2434 Parkuille s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or complication Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Squarrous Cell Carcinomo Metastatic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown 4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day Yea 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 🗍 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral i 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day 5 Pending investigation 1 🗌 Yes 2 🗀 No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Dey, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) APR 0 9 2010

Hhew

Conerman, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

600 North Wolfe St, Baltimore, MD, 21287

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Linwood Henry Boyd 6:45P [™] 2010 April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Apt.10 1224 Rossiter Ave Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 1 Months Days 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Now 1 2 2 2 1 1 9 2 5 85 Director 219 18 5291 I sual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d Inside City Limits within 72 hours after death with the Maryland Director MD n/a Baltimore ¥☐ Yes 2☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 USA 1224 Rossiter Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

Yes 2 No Navy Black White etc. Š 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Shipping 12th Merchant Seaman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Leathers Warren Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1224 Rossiter Ave. Apt.1C Balto, Md. 21239 Eric Boyd (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₩ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) injury or Apr.15,2010 OwingsMills,Md. Garrison Forest 21. Signature of Furieral Service Calwin Ades Scruggs Funeral Home Ε. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEART DISEASE Physician/ disease or condition resulting in death) Medical (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Vear Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performed Yes 2 death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titly 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year,

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Brown Physician/ 1:35 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 19SHINGTON Adventist MontGomer lakoma If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral 1 M 2 X F 224385550 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD tort Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Amer Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 3

✓ Widowed 4

☐ Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Jeaning TH 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lec Johnson JOHNSON-SWILLTMAN THA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Amer DR., Mysses Walltower FT. Wash. Mi 1500 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State arver (SUFFOIK, VA. emetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 420 HST. Ne. B.K. Henry Funeral Home wash, DC. 20002 enus m01178 23a. Part 1. Seer the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final MOCK Physician/ disease or condition resulting in death) Medical Examiner Sequentially list our dilives. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit that initiated events resulting in death) Last nding physician Physician/Medical Luouse the as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? ximono 2 🗌 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 Z No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check person who completed cause of death (Item 23a) (Type, Print) Zd + Z16. Kockville MD 2085Z 701 Randolph

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

of Vital

10-02694 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lawrence Jay Bensky State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day April 6, 2010 1705 hrs Medical Examiner LAWRENCE BENSKY 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** 2620 Butler Road @ Dover Road Butler 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Funeral Months Days Hours Director 1X M 43 04/16/1966 2 F 216-82-0942 Usual Residence of Decedent 10d Inside City Limits 10a State 10h County 10c. City. Town or Location 1 Yes 2 X No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Heath and Mental Hygiene.
Important: If item 27 is answed other than "matural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. MD BALTIMORE OWINGS MILLS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? COURT 11 OUARTERHORSE **USA** Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Married Armed Forces? 1 Never Married Yes Specify: WHITE 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year ò 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GENERAL CONTRACTOR CONSTRUCTION 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be STANFORD BENSKY LOIS SELIGMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMARA BENSKY / WIFE 11 OUARTERHORSE COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State OHEB SHALOM MEM. PARK 104/08/2010 REISTERSTOWN , MD 4 Donation 5 Other Specify 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Prvice Lie 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a Part I. Enter the disease Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical After this certificate has been signed by the attending physician : funeral director, page 2 should be detached for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes ဥ 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Apr 6, 2010 bicyclist struck by car within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural 0000 hrs 5 Pending 1 Yes 2 ✔ No 2 🗸 Accident nvestigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2620 Butler Road @ Dover Road, Butler, Md. (Specify) Major Road / Highway Homicide 29a. Certifier 1 [(Check only 1 one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 7, 2010 47 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

APR 09

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State of Maryland / Department of Health and Mental Hygiene

		1 - State of Marylan State of Marylan		artment of F <i>tificate of L</i>			giene Reg. No.20	10 10900
Physici		1. Decedent's Name (First, Middle, Last) Virginia Dare Colony				2. Date of De Month April		3. Time of Death 12:30 PM
Med Exami		4a. Facility Name (if not institution, give street and number) Collington Episcopal Life Care	Comm.	4b. City, Town, or Mitchel	Location of Death	I	4c. County	
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 207–07–8514 1 1 M 2 1 F 99		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 04/09/2	th	Birthplace (State or Foreign Country) PA
		Usual Residence of Decedent	y, Town or Loc	eation				10d. Inside City Limits
Marylar :8a-f sh tiffied a	Director		chellv					1 🗆 Yes 2 No
with the I s 23a or 2 ust be no	Funeral Di	10e. Street and Number 10450 Lottsford Rd.		10f. Zip Code 20721			10g. Citizen of V	Nhat Country?
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any highy or other traumatic event, the Medical Examiner must be notified at. once.	ed by Fun	11. Marital Status 1 Never Married 2 Married 3 Nidowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces 1 No If Yes, Give Year or Dates.	If	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Blac	e - American Indian, ck, White, etc. White
215-0 in 72 hour e. nan "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k life. DC	O NOT use retired)	ation during most of worki	ng	16b. Kind of Br	usiness Industry
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ylanc Id be file Mental H larked o atic eve	2	Preston Eroley			18. Mother's Name		Maiden Surname	*)
Mar d 2 shou alth and 27 is m		19a. Informant's Name/Relationship (Type, Print) Steel Colony/Son			and Number or Rura			itate, Zip Code)
Baltimore, Maryland 21215-0036 oemit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", only injury or other traumatic event, the Medical Exam once.		1 Rurial 2 Cremation 3 Removal from State	Place of Dispos emetery, crem	sition (Name of natory or other place ce Crem.	! [Date ,		City or Town, State
Balt permit. Depart Import any inj		21. Signature of Funeral Service Diceasee moo3			^{ss of Faci} lt∛app ve. Silve			emation Service
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Medical Examiner			ence of):					
lst se l	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury	ence of):					
icate be executed physician and sthe burial-transit	al Exa	that initiated events c. Due to (or as a consequence)	ence of):					
3760 fficate b g physic as the b	Medical	d						
or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 9 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Fetal 9 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birth 2 ☐ Unknown 1 ☐ Live Birt	l death 3 🔲	Ectopic pregnance Other (specify)	у		23d. Dat	te of delivery inth Day Year
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Division of Vital Records, tal or Attending Physician: The law requires is after death. al Director. After this certificate has been signed in by the funeral director, page 2 should b.	Completed by		Jan	_		24a. Was a autop	rmed?	Were autopsy findings available prior to completion of cause of death?
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	me, farm, stree	M 1 🗆 '	Yes 2 No	28f. Location (S	treet and Numbe	er or Rural Route Number,
DIVI pital or ours afte eral Dir		building, etc. (Specify)		aggreed at the time	dete and place and	City or Tow		
the Hos hin 24 h the Fun	Medical	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of m	and/or investig	gation, in my opinion eath occurred at the	n, death occurred at time, date and place	the time, date as	nd place, and due	e to the cause(s) and manner stated.
Vitt Cor		29b. Signature and title of certifier		29c. License	number 5079		29d. Date signed	(Month, Day, Year) 7 - 20:0
15		30. Name and address of person who completed cause of death (Item	23a) (Type, Pr	int)	wex P	n# #	Lan	itam MD
Sta Registr		31. Date filed (Morith, Day, Year) 32. egistrec's Signatu	ure	CLUDY	cher k	V 300		20706
negisti	ar	APR 0.9 2010 December 1	1. 100	A.C.				

DHMH 17 Rev 7/2009

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			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of L	Jealii	2. Date of De	Reg. No.	UT	3. Time of Death	
	Physicia Medio		Fred Earnest Cr	osswhite					31, Day 2010	rear	8:44 A M	
	Examin		4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of	f Death		
			101. Hollins Fe			Glen Bu			Anne A	Arund	el	
	Funeral Director		5. Social Security Number 6. Set	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir		9. Birthplac V 1121	nce (State or Foreign	
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	ith th	rall	107 Woodbury Drive			10f. Zip Code 24370)		U.S.A.	0g. Citizen of What Country?		
	eath w	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.		Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		- American	Indian,	
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Baltimore, Maryland 21215-0036	should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	1					Maiden Surname)			
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Rall	permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service license	men	D 22	R. Hende 48 E. Ma	erson Fun En St., S	eral Ho	me e, VA 243	370		
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	ications that caused the dear	th. Do not ente	er the mode of dying	g, such as cardiac	or respiratory an	rest,	Aj	pproximate nterval Between	
~	h sician/	i o	Immediate Cause (Final disease or condition resulting in death)	Maliga	an /	Mel	choma	an ei	Tos707c		Inset and Death	
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Records,	v requ	Completed						24a. Was		re autopsy	/ findings available	
C L	The lay ate has	oml						autop perfo 1 🗆 Yes	ormed? dea	or to compl ath? Yes 2 [letion of cause of ☐ No	
VItal	cian: ertifica ector, I	Be (25. Was case referred to medical examiner?	ospital:		-	ace of Death (Chec			- 6	on i o	
_	Physic this c	6	1 ☐ Yes 2 🖾 No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatien		4 ☐ Nursing H		dence 6 X Other (Specify) R	on's esidence	
DIVISION OF	ding th. After funer	cate	1 Accident Investigation	(Month, Day, Year)	injury	28c. Injury work' M 1 🗆	γ aτ ? Yes 2 □ No	28d. Describe h	ow injury occurred			
ISIO	• Atter er dea ector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify					Street and Number of	or Rural Ro	oute Number,	
2	i ital or Jurs aftural Dir ral Dir lled in							City or Tow			N	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 72 L. Medical Examin	cian: To the best of my know er: On the basis of examinatio Practioner: To the best of m	n and/or invest	igation, in my opinio	n, death occurred a	t the time, date a	ind place, and due to	the cause	(s) and manner stated.	
-	To the within the complete com		29b. Signature and title of certifier	with at	^	29c. License			29d. Date signed (A	Month, Day,	v, Year)	
			30. Name and address of person who co	7				<u>/</u>	19.11	, ~ 0	0/0	
			Mayer Gorbaty, M.			Dr. #312	Glen Bu	rnie, M	D 21061			
	Stat Registra		31. Date filed (Month, Day, Year) APR 0.9.20	32. Pegistrar's Signa	dure.	arke						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Joseph Collurafici Sr. Apri 1 5:15A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 3449 Howell Court Abingdon 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea March 30. 9. Birthplace (State or Foreign 212-40-2478 1 🔽 M 2 🗆 F 68 Country)
Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Abingdon Harford Md. 1 ☐ Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 USA 3449 Howell Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. ò 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 X No White 1 ☐ Yes 2 X No Specify: "natural", 3 ☐ Widowed 4 ₩ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Printing Company Shipping & Receiving Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude E. Quinn <u> Vincent S. Collurafici,</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. Collurafici, Jr. Son Yew Court Essex, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (SpecifyEmtombment 4-10-2010 Balto. Md. Gardens of Faith 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Phasenle 50 months Medical resulting in death) Due to r as a co sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause and ter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28c. Injury at work?

1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number.

P.O. Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Maryland 21215-0036

Baltimore,

State Registrar

Medical

29a Certifier

only one

MICHAEL

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUERBACK.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Peģistrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Day} 2010 Henry Clark Sr. 8 11:25 A M April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1736 Stokesley Road Dundalk Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Months Hours January 15, Maryland Director 215-30-6265 '1935 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natures" or account. 10a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1736 Stokesley Road 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Post Office Mechanic <u>12 years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Strauss Howard Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1736 Stokesley Road, Dundalk, Maryland 21222 wife Ruth Clark other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Apri Γ^{Date} 9. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 injury Bayview Crematory Baltimore, Maryland 2010 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. Signature of Funeral Service Licenses 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physicians disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Month Day Year Pregnant at time of death Other (specify) Yes 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 12 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an this certificate has performe 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural iniury work? 5 Pending 2 🗆 No Accident Investigation after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 Homicide determined within 24 hours a To the Funeral C Medical 🗠 Certifying Physician: To the best of my knowledge, death 👊 Gured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or inver Certifying Nurse Practioner: To the best of my knowledge igation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) 5

State Registrar

DHMH 17 Rev 7/2009

Philope

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MOL last birthday) 8. Date of Birth Age (In yrs 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. 1 M 2 XF Months Hours (Month, Day Director Usual Residence of Decedent ems 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🕱 Yes 2 🗆 No more 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) omem Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ 19a, Informant's Name/Relationship (Type, Print) glaughter) 19b. Mailing Address Town, State, Zip Code) Kat Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service Licen 21. Signatur Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final 5 Physician/ Vroci disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine signed by the attending physician and d be detached for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page 2 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? funeral director, Certificate: To Be 26. Place of Death (Check only one) Hospital: Other: 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 / Natural 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 24 hours after death Funeral Director: the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) the within To the

State Registrar 29b. Signature and title of certifier

DELLONTO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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trar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Henry Cooper 11:00 PM APRIL 77_ 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care - Woodbridge Valley Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Min. 241-50-6573 Director July 19 1924 S.C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Itw Madical Eventine must be notified at MD BALTIMORE Director NA 1

Yes 2 □ No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 125 S. Culver Street 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ∐Yes 2√∑No Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cooper Clara Wilson Joe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 S. Culver St. Almetta Cooper - Wife Balto. Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) London Park Cem. 4/8/2010 Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March Funeral Home West, Inc. 4300 Wabash Ave. Balto. MD the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21215 23a. Part 1. Enter the list ase, or complications that caused shoot, or heart finiture. List only one cause on each line Approximate Interval Between Onset and Death Immediat Cause (Final **Physician** UCMONHRY EMBULI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be exec Due to (or as a consequence of) physician a the burial-t Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 1 ☐ Yes 2 ☐ No Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, sign EMEN TH 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown ALCOHOL ABUSE Were autopsy findings available prior to completion of cause of death? 24a. Was ar page 2 s autopsy performed 1 ☐ Yes 2 XNo 2 X No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural Natural 5 Pending I hours after death.

uneral Director: A

ely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number D0061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 WILKENS AVE # 307 BALT. MUD 21225 QUAINOOMO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mari 10:45 AM Dorothy G. Chearney Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore-Washington Medical Center Glen Burnie 8. Date of Birth
(Month, Day, Year) <u>Anne</u> Arunde1 Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Hours Days Country) Marvland Director 219-30-0352 191 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕅 No Maryland Anne Arundel Pasadena 6 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Funeral items 23a 88 Wileys Lane 21122 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i ģ 1 Never Married 2 Married Baltimore, Marýland 21215-003(If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert William Holland Annie Ellen Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Chearney (Son) 88 Wileys Lane Pasadena, Maryland 21122 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Atlantic Cremation 4/7/10 Glen Burnie, Maryland 21. Signature of Funeral Service Lice Name and Address of Facility Cully-Polyniak Funeral Home, P.A. IR Mountain Road Pasadena, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a densequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Completed 2 No 3 Probably 4 Unknown 1 Yes peen Were autopsy findings available prior to completion of cause of death? 24a. Was an In the Funeral Director After this certificate has I To the Funeral Director After this certificate has I at the Funeral Director After the Funeral director, page 2 s autopsy 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ျ 1 Tes 1 Minpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) Natural 2 Accident 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge eth oncumo et the time, date and place, and due to the causa(e) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** artledge /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL GEORGE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1□M 2XF 578-58-801 SOUTH 10 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director terght's MI APITA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe TRO Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: if them 27 is marked other them:
any injury or other trainments. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NeiGHTS, MI APITAL artlenge/ SPOUR Jonathan 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 3 Removal from State 1⊠ Burial 2 ☐ Cremation andover, Mi Warmony Memoria 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Wash, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each initial. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clearh. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significa conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 V Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred examiner? to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified who completed cause of death (Item 23a) (Type, Print) 30. Name and ddress of perso Year) 32. Reg State Registrar

DHMH 17 Rev 1/2001

20

29b. Signature and title of certifier

Ana Rubio MD. 31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

egistrar's Signatu

DHMH 17 Rev 1/2001 **OCME 2006**

State Registra

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 4, 2010

29d. Date signed (Month, Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, **Funeral Director:** 24 hours within 24

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year).

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ramesh Sabapath 201-168 Back Rove Meck Road Bath more Many by 2122 Sabapalm

back

29c. License number

D 30641

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day April 6, 2010 Medical Examiner Robert Doty 2047 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3609 Hudson Street Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months Days Hours Director 214-76-2442 $_{1}X_{M}$ 51 11-28-1958 2___F Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once. MD N/A1 X Yes 2 No Baltimore more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3609 Hudson Street Ö 21224 USA 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Black, Was Decedent Ever in U.S. Funer If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 X No 1 Yes 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White δ, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 N/AVending Mechanic Vending 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) (UNK) Frederick Anna Horky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Scheiner Sister 4022 Cloverland Dr. Phoenix, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Itimore, crematory or other place) Important: If it 1 Burial 2 Cremation 3 Removal from State 4 - 12 - 10Baltimore, MD 4 Donation 5 X Other Specify: Entombment St. Stanislaus Cemetery 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses Avenue Baltimore Dundalk Physician 23a / Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and (Madient Death a. Complications of chronic alcohol abuse Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ned for use as the burial - transit Division of Vital Records, P.O. Box 68760, rial or Attending Physician: The law requires that the death certificate be executed d. Physician/Medical UNPENDED **AMENDED** IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown certificate has been signed by the attrector, page 2 should be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 DOA After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Director: / 1 Yes 2 No 5 Pending hours after death 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 뗭 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 7, 2010 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State arke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PII per MD G903 5/19/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2010 5:45 P.M Lee E. Del Prete Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Days Hours Min.

Dec. 27 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ፟ M 2 ☐ F 68 Yrs 1941 Director 212-40-1195 Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f shov idical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location death with the Maryland Director 1 🗌 Yes 2 🔀 No Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 6007 Burnt Oak Road 21228 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) filed within Pizza Delivery Business Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If Item 27 is marked of any injury or other traumatic even once. and Mental Fishers is marked of ည Ann Sartoff Eugene Del Prete 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6007 Burnt Oak Road; Catonsville, MD 21228 Carolyn Del Prete Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4-9-2010 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville, MD 21228 21. Signature of Funeral Service Lic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CELL LUNI CANCER, METASTATIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last **To the Hospital or Attending Physician**: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 🔲 Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes EMPHYSEMA 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been siç , page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Major depressive disorder autopsy death? within 24 hours after death.

To the Funeral Director. After this certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be B examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Cother (Specify) HOSPICE Certificate: To 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation the f 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Description of the Description of t Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number APRIL7, 2010 64395 4+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N CHARLES ST, SUITE 4105 BALTIMORE, MD 21204 DANIEUL DOBERMAN, MD 31. Date filed (Month, Day, Year) 32. Registrar' Signature State barks Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vantage House Columbia Howard 8. Date of Birth (Month, Day, Yea Oct 25, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Year) 1 M 2 □ F 72 Alabama 426-68-5601 1937 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5059 Whetstone Road 21044 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give' Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: <u>6</u> Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University of Elementary/Secondary (0-12) College (1-4or 5+) Maryland Professor Termit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important; If Item 27 Is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter George Van Egmond Lois Norman Everett ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rick Van Egmond /Brother P.O. Box 247 Bolton, MS 39041 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apr 06 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation / 5 ☐ Other (Specify) Chesapeake Crematory 2010 21. Signature of Funeral Service License 22. National distriction of antity Funeral Alternatives Hockernan 8717 Green Pastures Drive Towson Maryland 21286 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage ND abstructure **Physician** Cheronic /Medical Due to (or as a consequence of): Examiner RSIOME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequent of): burial-trar Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence ² 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3□ DOA 6-Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

certificate be executed Box 68760, physician attending p Ö the ģ σ. Records, certificate has Division or Vital spital or Attending Physician; this After death. neral Director: Funeral hours

within 72 hours after death with

altimore, Maryland 21215-0036

completely the 2 Registrar

State

29a. Certifier

29b. Signature and title of ce

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year) -

			Registrar	Cei	rtificate of <i>E</i>	Death		Reg. No.		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	07 04, Day 201	o Year	3. Time of Death
ě:	Medic		William Edison Elliott					04 , 3201	0.50	4:00 Ам
	Examin	er	4a. Facility Name (if not institution, give street and number) 3514 Revolea Beach Road		Middle				of Death imore	
	Funeral Director		5 Social Segurity Number 1 M M 2 F 7. Age (In y	rs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 01/05/	h 1935	9. Birthplace (State or Foreign Country) West Virginia	
р	low tt	L	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation				1	0d. Inside City Limits
Marylan	28a-f sh otified a	Funeral Director	Maryland Baltimore	Middle						1 ☐ Yes 2 🔀 No
th the	3a or be n	al D	10e. Street and Number		10f. Zip Code			10g, Citizen of		try?
ıth wi	ms 2; musi	ner	3514 Revolea Beach Road 11 Marital Status 12. Was Decedent Ever in	11.6	2122 Was Decedent of Hi		acify Vas or No-	U.S.A	e - America	an Indian
er de	or ite niner	by Fi	11. Marital Status 1 □ Never Married 2 🛣 Married 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 😿 No		If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		ck, White, e	
Irs aft	ural", I Exai		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2X No	Specify:		Specify	Whi	te
2 hor	"natı edica	plet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o	ation during most of wor	king	16b. Kind of E	susiness Inc	lustry
ithin 7	ene. r than the M	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)		ONOT use retired) nbly Line	Worker		Auto M	anufa	cturer
should be filed within 72 hours after death with the Maryland	nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Trumman Elliott			18. Mother's Nan Julia Ar	, ,		e)	
= 0.	Ith ar 27 is trau		19a. Informant's Name/Relationship (Type, Print) Stella Elliott (Wife)		ng Address (Street a Revolea					ode) and 21220
	O == =		1X Burial 2 ☐ Cremation 3 ☐ Removal from State		osition (Name of matory or other place of Faith	e) 04/10	Date 0/2010	20c. Location	•	
Dalui permit. P	Department Important: any injury o	÷	21. Signature of Funeral Service Licensee		2. Name and Addres					
a 8,	를 들 등 등		1352		1407 Old	Eastern /	Avenue,	Essex.	Maryl	and 21221
			23a. Part 1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.	leath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,		Approximate Interval Between
	sician/ Medical	0 1	Immediate Cause (Final diseas or condition a. Due to (or as a constitution of the condition)		rema					Onset and Death 2 years
	aminer		Due to (or as a cons	e fuence of						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):		,				
ertificate be executed	physician and the burial-transit	Examiner	Cause (Disease on illinguy that Initiated events c. Due to (or as a consessition of the consessition).	requence off:		/				
7 %	ician burial	calE	resulting in death, East	roquerios erj.						
icate	ng phys as the	/Medical	d							
box of e death certif	eg di-	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pre 1 □ Live Birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	sy			ate of delive	ery Day Year
s that the	igned by be detac	ğ	Part II. Other significant conditions contributing to death but not	resulting in the u	underlying cause giv	ven in Part I.	23e. Did to			e cause of death?
aw requires	peen s	letec	Ashestosis Corcurona of mon	+9			24a, Was			osy findings available
The law	ate has l page 2 s	Completed	Carewona of moi	r-			autop perfo	osy ormed2	prior to cor death? 1 \(\sum \) Yes	npletion of cause of
cian:	sertific ector,	Be	25. Was case referred to medical examiner?		26. Pl	ace of Death (Chec				
Physi	this craft dir	5	1 ☐ Yes 2 No Hospitat: 1 ☐ Inpatient 2 27. Manner of Death 28a. Date of injury	28b. Time of	nt 3 🗆 DOA	4 L Nursing H	ome 5 Resid			
oding .	ath. : Aftel e fune	cate	1 Natural 5 ☐ Pending (Month, Ďay, Year 2 ☐ Accident Investigation	r) injury	work	? Yes 2 □ No	200.000.00	, o , , , , , , , , , , , , , , , , , ,		
al or Atte	s after des I Director Id in by th	Certificate	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rural	Route Number,
ne Hospit	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atten completed filled in by the funeral director, page 2 should be detached for us	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the best of examiner only one) 3 Certifying Nurse Practioner: To the best of the control of the contr	ation and/or inves	tigation, in my opinio	on, death occurred	at the time, date a	ind place, and du	e to the cau	se(s) and manner stated
Tot	To t		29b. Signature and the of centifier the succession of the successi		29c. License	1846		29d. Date signe	d (Month, L	Day, Year)
			30. Name and address of person who completed cause of death (Print)				,	
	13		MARTIN SHERIDAN, M.D., 6	330 V	HOSPITAL	DR.	BALTS	.,MD	. 21	237
	Stat	te	31. Date filed (Month, Day, Year) 32. Registrar's Si							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh g902 4-9-10 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Concetta F. Eicholtz М 2010 April 6:55 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 7 192 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 1 M 2 F Days Hours Min 219-18-3173 84 1925 June MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Rd. #615 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceus. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 x No Specify: 3 Divorced Specify white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 n/a Manufacturing Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mario Guzzo Salvatora Congelosi Cangelosi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William B. Eicholtz/husband 2525 Pot Spring Rd., Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4/12/10° 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD Signature of Funeral S Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael Part 4. Enter the dise se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death disease or condition resulting in death) END STAGE DEMENTIA Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown

Physician/ Medical Examiner Examine

Physician/

Medical

Director

Funeral

by

Completed

Be

ပ

Examiner

Funeral

Director

er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

alth and Mental Hygien 127 is marked other the er traumatic event, the

permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic eve

death

72 hours after 21215-0036

filed

Baltimore, Maryland

certificate has been signed by the attending physician and irrector, page 2 should be detached for use as the burial-transi After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of

or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

CONCETTA EICHOLTZ

Physician/Medical

Completed by

Be

25. Was case referred to medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 K No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Hor	me 5 Residence 6X Other (Specify) HOSPICE							
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) injury		28d. Describe how injury occurred							
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, obuilding, etc. (Specify)	office 2	28f. Location (Street and Number or Rural Route Number, City or Town, State)							

ျာ	1 ☐ Yes 2 🗶 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing H	Home 5 Residence 6X Other (Specify) HOSPICE								
rtificate:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b		28c. Injury at work?	28d. Describe how injury occurred								
al Certi	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Medic	(Check 2 ☐ Medical-Exami	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state.										
	29b. Signature and title of certifier	^	29c. License number	29d. Date signed (Month, Day, Year)								
	1	42	1 14372	5-14/8/10								

8

within 24 hours a To the Funeral C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD, MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #7, per Fh G902 4/13/10 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear **Physician** Month Day EADDY DUISE 2010 11:40a April 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Future Care -Lochearn Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F 84 94 219-20-5023 Director Mar. 7, 1916 S.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notifled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ∏Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ms 23a or 7 r must be n 833 Lenton Avenue 21212 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify.Black Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Worker 18. Mother's Name (First, Middle, Maiden Surname) NΔ Domestic 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fill Health and Mental H tem 27 is marked otl Willie Stewart Josephine Forrester ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 833 Lenton Avenue Baltimore, MD 21212 Pages 1 at Tent of Heat, It: If item 27 James A. Watts - Nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4/9/2010 4 □ Donation 5 Other (Specify) Randallstown, MD King Mem. Park 21. Signa re Funeral Service Licensee 22. Name and Address of Facility Baltimore, MD March FH-West 4300 Wabash Ave. 21215 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) Physician 2 years /Medical Due to (or as a consequence of): Examiner 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2X No 1 Tes 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has page certificate 1☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 ☐ D0A this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely k only (Che one and manner stated within 2 29b. Signa and : 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN DO05 90 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON BLUD 32. Registrar's Signature 31. Date filed (Month, Day, Year State Registrar 3) [14]

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Voor MARTE HELEN EBBERTS 5:35 P M April 06 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Baltimore UNION MEMORIAL HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day Year)

1947 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Days Hours 62 Director Yrs. Maryland 212-48-3219 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director N/A Morrell Park 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21230 2719 Marbourne Avenue death \ Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 'natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: White Specify: Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event the page. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Cochran Elsie Lowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) 2719 Marbourne Avenue, Baltimore, Maryland 21230 Walter H. Ebberts Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 7, 2010 Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Consestiv Medical Examiner Due to or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year be detached 9 Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed?

Yes 2 No 1 🗌 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Tes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier ZAARA PAKSAT, MD

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

Union Memorial Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAKBAT

APR 11 Q

ZAHRA PR 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mildred Month. Murray 2010 Ford 9:40 P M DIE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Doctor's Community Hospital Prince George's Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, April 1 Director 181-22-7363 92 1918 South Carolina Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 38a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10d. Inside City Limits 10c. City. Town or Location Director Prince George's Bowie MD 1 🗌 Yes 2 🛂 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20716 USA 15005 Health Center Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖺 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify: 3 XWidowed 4 □ Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Medical (Specify only highest grade completed) Health Care Elementary/Seconday (0-12) College (1-4 or 5+) Records Technician Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Murray Willoughby Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7013 Kingfisher Lane Lanham, MD Elizabeth Rankin Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4/14/10 4 Donation 5 Other (Specify) Penn Lincoln Mem Park North Huntingdon, PA 22. Name and Address of Facility Robert A. Waters Funeral Home 21. Signature of Funeral Service Licenses 2326 Jenny Lind St. McKeesport, PA 15112 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, æ 26. Place of Death (Check only one) Hospital: Other: ျ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Deat 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred Natural Accide injury 5 Pending 2 No Accident Investigation after death Director; / filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined e Funeral C 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year, UZABETH 30. Narge and address of person who completed cause of death (Item 23a) (Type, Print) 6,000 LUC 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lois Carmel Funk April 2010 3:47 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 13 F 12/26/1927 Director 220-20-1067 82 Maryland Usual Residence of Decedent r 28a-f show 10h. County 10c, City. Town or Location 10d. Inside City Limits Director 1 ∏Yes 217 No Maryland Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? raf", or items 23a or : hours after death with 10304 Vincent Farm Lane 21162 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐Yes 2 No 1 Never Married 2X Married r than "natural", or If Yes, Give Year or Dates: 1 □Yes 2x No Completed by Specify Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Statistician Aero-Space 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental Charles Edward Harris Lois Estelle Parris ဂ္ဂ Department of Health and Milliand Milliand Milliand Milliand 27 is mark any Injury or other traumating 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert S. Funk (husband) 10304 Vincent Farm Lane, White Marsh, Maryland 21162 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/12/2010 Baltimore, Maryland Bavview Crematorv 21. Si nature di Europa Service licensee 22. Name and Address of Facility Bruzdzínski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi La Cause (Final diseas or condition resulting in death) Physician Bilateral pricimonia yays /Medical Due to (or as a consequence of): Examiner months Faulun Sequentially list conditions. Physician/Medical Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Corman burial-trar 460 VS Due to (or as a consequence of): meruta the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) the 9 Unknown à s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onle one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ours after death.

neral Director: A
filled in by the fu within 24 hours a the Hospital

Baltimore, Maryland 21215-0036

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number DO47223

State Registrar

Medical

NID 6701 Daren m.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month THELMA NANCY FABER 5:00 P ^M 2Ó10 April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shangri La Assisted Living Facility Ellicott City 5. Social Security Number 8. Date of Birth Month, Day, June 23, If Under 1 Year | If Under 24 Hrs. Funeral 6. Sex Age (In yrs, last birthday) 9. Birthplace (State or Foreign Days 1 M 2 X F 215-01-1294 96 °1913 Mary Land Director Usual Residence of Decedent shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 3 8 1 N/A Maryland 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Light St., Apt. 635 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 21 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) American Can Co. Packer marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Warren Dixon Elizabeth Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5549 Dolores Avenue, Baltimore, Maryland 21227 .8 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Michele Toebbe (Granddaughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Cedar Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State 4/6/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Athen sclerotic CardioVarcula Dixease Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last trar and Due to (or as a consequence of): physician a street burial. Physician/Medical Box 68760 nding IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Por in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Unknown signed by the a g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy death? 1 Yes Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Living Other: 4 Nursing Home 5 Residence 1 🗌 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Funeral Director: After this completed filled in by the funeral di 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury death. 1 Yes 2 🔲 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D 30641

0

DHMH 17 Rev 7/2009

State Registrar Back River Weck Road Baltimore May land 2/22/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201-109

32. Registrar's Signature

Sabapalhi

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #17, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Green 3:40 FM Physician April 02 2010 avid /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. **X**□M 2□F Months Days Hours MD 29 216-96-8583 8-11-1980 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🔀 No Director St. Mary's MD <u>Lexington</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code items 23a 20653 U S Funeral 21486 Sidney Drive Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2XXNo If Yes, Give Year or Dates: Specify: Black ð 3 Widowed 4 Divorced "natural" A and Mental Hygiene.

It is marked other than "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Painter llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David A. Green II Sr. Carolyn Pack မှ _{Code)} apt 21144 370 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1675 Nead Circle Road Severn, MD permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau Carolyn Green-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4-10-2010 Mt Zion United Magothy, MD 4 ☐ Donation 5 ☐ Øtper (Specify) 21. Signature of Funer 22. Name and Address of Facility March East F/H ervice License 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cerebral ancur disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events and burial-trai resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 TEctopic pregnancy ☐ Live birth 2 ☐ Fetal dea ☐ Pregnant at time of death Month Day in the past 12 months? 5 Other (specify) Yes 2 □ No 9 Tunknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 Yes 3 Probably 4 Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Yes 2 No 2 Accident death. s after death the f Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide City or Town, State) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES 000 03 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VU2 600 North Wolfe St, Baltimore, MD, 21287 enrantio 32. Registrar's

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Charles Francis Getz, Jr. 07 2010 7:00 April Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 2900 Boarman Ave. Baltimore 8. Date of Birth (Month, Day, Year) Dec. 15 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Months 1 X M 2 🗆 F Days Hours 220-40-9679 67 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland notified at Director Baltimore 1 X Yes 2 No N/A Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ral", or items 23a or Examiner must be Funeral 21215 USA 2900 Boarman Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No þ 1 x Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Claims Adjuster 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Leona L. Flashell permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Charles F. Getz, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Ratna Court Baltimore, Md. 21236 Mr. Thomas L. Getz/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Buriai 2 Premation 3 🗖 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Co. 4/8/2010 Towson, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death ocard. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Tobably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 1/2 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? Other: 4 \(\text{\text{Nursing Home}}\) 1 Nursing Home 5 \(\text{\text{Residence}}\) Residence 6 \(\text{\text{\text{Other}}}\) Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 8, 2010 D0026748 Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 BALTO MD2(21) 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

3. Time of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician
/Medical
Examiner

OSEPHIN

romac

Division of Vital Records, P.O. Box 68760, this After

2. Date of Death Month Day 3 Year 9:35 PM Josephine V. Gromacki April 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Square Hospital Center Rosedale Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Months Hours Min 1 □ M 2 □ F Days 93 Yrs. Director 216-09-7940 July 2,1916 Pennsylvania Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner near be notified at 1 ☐ Yes 2 XNo Director Md. Balto. Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 9600 Haven Farm Rd, Unit D 21128 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No Specify: <u>\$</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) es 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Communcications 10th17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carmelo Franz Anna Passalacqua ٥ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Constantini 8 Barletta Ct. Rosedale, Md. 21237 permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other? 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 4-7-2010 4 Donation 5 Dother (Specify) Most Holy Redeemer Balto. Md. Signature of Eureral Service Licen 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** theumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) been signed by the should be detached □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy perform 2 X No ı∐Yes 2 □ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 Accident the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal (Check only one) Medi within 2 To the 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BINH 10 NOUTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 21237 Dinh Nguyen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April 6,2010 8:03P Clara S. Goralski 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Harford Upper Chesapeake
5. Social Security Number 6. Se BelAir | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Bi | September 20, 1916 If Under 1 Year Months Days 9. Birthplace (State or Foreign 16 Maryland 7. Age (In vrs. last birthday Months 1 □ M 2 🗓 F 93 218-01-4276 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 🛛 No Joppa Harford 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 1403 Joppa Forest Dr. Unit E 21085 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Specify. Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 th College (1-4or 5+) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Waleria Hepner

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

2010

Approximate Interval Between Onset and Death

days

Balto.Md.

Nottingham, Md. 21236

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Joppa Forest Dr. Unit E Joppa, Md. 21085

Date

4-10-2010

9705 Belair Rd.

22. Name and Address of Facility Schimunek FuneralHome

28a-f show 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, Ire Marical Examination and be notified Baltimore, Maryland 21215-0036 Department of Health and Mental Hygie Important: If item 27 is marked other I any injury or other traumatic event, II Pages 1 and 2 should be Soralski

Physician

Examiner

Funeral

Director

/Medical

10a. State

Sylvester Cholewczynski

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4□Donation 5XOther (Specify) Entombment

-ale

Acyte

DTR.

Due to (or as a consequence of):

NNENNA LICHENDY

32 Registrar's Signature

UPPER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UCHENDU

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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus

19a. Informant's Name/Relationship (Type. Print)

21. Signature of Funeral Service Licensee

Shirley A. Brady

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

NNENNA

Md.

Director

Funeral

þ

Completed

Physician 7Medical Examiner

attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, signed by the a page

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Completed Certification: To After 1 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical

lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			- 19 &							
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 No 2 No 2 State of pregnancy 1 Listensia at time of death 2 Other (specify)										
Completed by Ph	Part II. Other significant conditions cor Hypertor	sion	e underlying cause given in Part I.	1 □ Yes 2 No	ontribute to the cause of death? 3 Probably 4 Unkno b. Were autopsy findings availal prior to completion of cause of death? 1 Yes 2 No							
Be	25. Was case referred to medical examiner?		26. Place of De	eath (Check only one)								
	1 Yes 2 No	ospital: 1 ∏Inpatient 2 ☐ ER/Outpa	atient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ C	Other (Specify)							
ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Tim Inju		28d. Describe how injury occu	urred							
Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	, street, factory, office	28f. Location (Street and Nur City or Town, State)	mber or Rural Route Number,							
dical (leath occurred at the time, date and pla or investigation, in my opinion, death oc									

29c. License number

D66136

CHESAPEAKE DR BEL AIR

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Iga-b per FH G902 4/14/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Day **Physician** 3:06 PM ELLA GRAY 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Doctors Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) 1 □ M 2 🖾 F Yrs Sept. 579-48-5544 96 1913 TL **Director** Usual Residence of Decedent permit. Pages 1 and 2 shoul; be filed within 72 hours after death with the Maryland De artment of Health and M. ntal Hygiene.
Im ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show ann injury or other traumatic event, It a Market Examiner must be notified at on. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No Director DC Washington 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 116 35th St NE 20019 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐ Yes 2 ⊠ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No \mathcal{O} \mathcal{C} \mathcal{A} \mathcal{A} \mathcal{A} Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: Be Completed by 3 ☑ Widowed 4 ☐ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Accounting Clerk Dept of Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Orendoff Grace Yokum ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Vernard R. Gray -Brother 4309 Miami Pl. -Gynn Oak, MD. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-12-2010 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Suitland, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a conse dence of): Examiner Tenc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the hirial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 $\creve{\zeta}$ Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 2 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only of Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Dettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check o within 2 To the I 29c. License number 29d. Date signed (Month, Pay, Year) 29b. Signa 163296 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Lan ham Mary kind 118 Good Lavio Michaels LUCK Road 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1	277.	partment of Health and M ertificate of Death	Reg. No. 2	10 10925						
Physician/	1. Decedent's Name (First, Middle, Last) Robert Lee Gribble, Sr.		2. Date of Death Month Day March 31st, 20	3. Time of Death						
	4a. Facility Name (if not institution, give street and number) Prince George's Hospital	4b. City, Town, or Location of Death Cheverly	4c. County							
Funeral Director	5. Social Security Number 6. Sex 1×10^{-7} Age (In yrs. last birthda 1×10^{-7}	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 25, 1935	9. Birthplace (State or Foreign Country) Maryland						
show !at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or		23,1733	10d. Inside City Limits						
e Maryli r 28a-f notifiec	Maryland Prince George's €linton	10f, Zip Code	T do on the	1 ☐ Yes 2 🛱 No						
leath with the Maryland teems 23a or 28a-f sho er must be notified at Funeral Director	9006 Cheltenham Avenue	20735	10g. Citizen of V							
, ra -	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. UNKNOWN	 Was Decedent of Hispanic Origin? (Speinf Yes, specify Cuban, Mexican, Puerto for Image) Yes 2 No Specify: 		e - American Indian, k, White, etc. White						
21215-0036 within 72 hours after liene. Than "natural", or the Medical Exami Completed by	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of workir . DO NOT use retired) Carpenter	ng N	provement						
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam To Be Completed by	17. Father's Name (First, Middle, Last) William Albert Gribble		(First, Middle, Maiden Surname WN)						
ore, Marylar 1 and 2 should be of Health and Ment fitem 27 is market r other traumatic e	19a. Informant's Name/Relationship (Type, Print) William A. Gribble/ Son 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zig 9006 Cheltenham Avenue, Clinton, Mary									
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Discernation State Cedar H	sposition (Name of rematory or other place) iii Cemetery April	1	City or Town, State d, Maryland						
Baltimor permit. Page 1 Department of Important. If if any injury or conce.	21. Singure of Funeral Service Licensee	22. Name and Address of Facility Mar 308 Suitland Road,								
Physician/ Medical	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deat of the Conset and Deat of the									
≝Examiner ö	Sequentially list conditions, if any leading to immediate cause. Enter Underlying									
(60 %) cate be executed physician and s the burial-transit edical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last c. Due to (or as a consequence of):									
X	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Dat	e of delivery nth Day Year							
uires that the signed by uld be detacted by Predetacted rt II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.		ibute to the cause of death? 3 □ Probably 4 🌂 Unknown							
VITAI KECOrdS, vysician: The law requires is certificate has been sig director, page 2 should b			autopsy p performed? d	Vere autopsy findings available whom to completion of cause of eath? Yes 2 No						
VITAI hysician: his certific I director,	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (Check		x (Coosife)						
oding Phy ding Phy tth. : After this s funeral c	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at 2	8d. Describe how injury occurre							
DIVISION OF all or Attending PP s after death. all Director: After the in by the funeral certificate:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	18f. Location (Street and Numbe City or Town, State)	r or Rural Route Number,						
the Hospita inin 24 hours the Funeral inpleted filled	29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, deat of my knowledge (deat only one) (Certifying Nurse Practioner: To the best of my knowledge)	estigation, in my opinion, death occurred at	the time, date and place, and due	to the cause(s) and manner stated.						
To t To t	29b. Signature and title of certifier A 1	29c. License number	29d. Date signed	(Month, Day, Year)						
4	30. Name and address of person who completed cause of death (Item 23a) (Type	HOSPITAL DR (Thereely m	D 20785						
State ³ Registrar	APR 0 9 2010 August 32. Registrar's Signature									

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Pauline Greenw		1- For State Certificate of Death								
Physicia Medical Exami	an/	Registrar 1. Decedent's Name (First, Midd				144	2. Date o	Day Year	3. Time of Death 0608 hrs	
Jean Lam	1101	4a. Facility Name (if not instituted 8832 Walther Blvd	on, give street and number			Town, or Location		7, 2010 4c. County of D Baltimore	eath	
Funeral		5. Social Security Number	6. Sex 7. Ac	ge (In yrs, last			der 24Hrs. 8. Date	of Birth (MM/DD/YYYY)		
Director		184-05-1413	1 M 2 F	90	Yrs. Mon				country) Ransy Vank	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location			<u>' </u>	10d. Inside City Limits	
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5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Director	10e. Street and Number 8820 Walthe	r Blvd, #	1205	10r. 2.	ip Code 2123	4	10g. Citizen of What	1 States	
ath with tems 2 st be n	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Decedent	?			rigin? (Specify Yes an, Puerto Rican, etc		merican Indian, Black, tc.	
fter de: ", or i			1 Yes 2	X No	1 Yes	2 No specif	iy:	Specify: \	white	
hours a	od be	15. Decedent's Education (Spe			Sa. Decedent's Usua	_	e kind of work done	16b. Kind of Busin	ess/Industry	
36 in 72 h	Completed	Elementary/Secondary (0-12)	Coilege (1-4 or	5+)	11.		1	0.	11	
5-003 fled withi Hygiene. I other th	E S	17, Father's Name (First, Middle	, Last)		HON	MCMQ 18.Moth	KEY er's Name (First, Mic	ddle, Maiden Surname)	Home.	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	a	Frank	Katherm	m.			Mae 1	Pursley		
MD 2. 42 should the and M as 27 is more immediate.	ပ္	19a. Informant's Name/Relations William Greenu	ship (Type, Print)		19b. Mailing Addres	ss (Street and No Hher Blvc		Number, City or Tam, S	State, Zip Code) Urvland 21234	
_ 4 7 7 7 2	1	20a. Method of Disposition	, ;		ce of Disposition (Na	ame of cemetery,	Date	arkulle, Me 20c. Location - Cit		
MOF Pages lent of int: If		1 Burial 2 Cremation 4 Donation 5 Other S		ate Parky	natory or other plac	etery	April 8,20	10 Parkull	e Manyland	
Baltimore, permit. Pages 1 a Department of He Important: If it injury or other to	ı	21. Signature of Funeral Service	Licensee	1,0,1,4	22. Name an	Address of Facil	Chanelt	Cremations	Services ,	
Physician	-	23a. Part I. Enter the disease, or	complications that caused	I the death. Do	8800	Hartord	Koad 1	Parkville M	D 2 D 3 4 Approximate Interval	
/Medical		failure. List only one cause Immediate Cause (Final disease	on each line.						Between Onset and Death	
Examiner		or condition resulting in death)	Due to (or as a cons							
	Je	Sequentially list conditions, if any, leading to immediate	b. Diverticulitis Due to (or as a cons	equence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a cons	equence of):					_	
O, e be executed /sician and burial - transit	Ä	events resulting in death) Last	d							
be executed sician and urial - transi	dical	UNPENDED	AMENDED							
OX 68760 eath certificate the attending physicon or as the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	me of pregnan	cy 2 Fetal deatl	h 3 Ector	oic pregnancy	23d. Date of del Month	ivery Day Year	
Box 6 e death cer the attendied for use a	Physician/M	past 12 months? 1 Yes 2 No 9 Uni	Lunguing C	time of death						
that the denoted by the state of detached for	P	Part II. Other significant condit	9 Unknown	h but not resul	Iting in the underlying	ng cause given in F	Part I. 23e.	Did tobacco use contribut	e to the cause of death?	
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ords, w requir	lete								e autopsy findings available to completion of cause of	
of Vital Records, ng Physician: The law require then this certificate has been si meral director, page 2 should b	Completed							performed? deat	h? Yes 2 No	
Vital Reo ysician: The his certificate director, page	a	25. Was case referred to medica examiner?	Hospital:			Other F	h (Check only one)			
n of Vir ding Physic After this funeral dir	P	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry 28	/Outpatient 3	DOA Other 4	Nursing Home	Residence 6 🗹 C	Other: Scene	
ion (tending eath.	tion	1 Natural 5 Pend 2 Accident Inve	(Month, Day,Y ding stigation	(ear)		1 Yes 2	No			
Division pital or Attendiours after death.	Certification:	3 Suicide 6 Coul		njury - At home	, farm, street, factor	ry, office building,		ion (Street and Number o wn, State)	r Rural Route Number, City	
Hospi 14 hou Funer ely fil	cal Ce	29a. Certifier (Check only 1 Certifying P	hysician: To the best of m							
To the within 2 To the complet	Medical	2 Medical Exa 29b. Signature and title of certifie	and manner stated.	Illination and/o		9c. License numbe		29d. Date signed		
	-	() (n. (n.	lenso			O.C.M.E.		April 8, 2010	,	
	ł	30. Name and address of person			•					
			ssistant Medical Exa		11 Penn Stree	et, Baltimore, I	MD 21201			
St Regist		31. Date filed (Month, Day, Year)		n's Signature	medel					

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amend items 5,17 per fh 9902 4-26-10 vt
State of Maryland / Department of Health and Mental Hygiene 2 | | | - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2:326 James E. Golley M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Saint Joseph Medical Center timore OWSON 215 Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, pay, Oct. 19 Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign ^{Year} 1930 1 🕱 M 2 🗆 F 219-28-0678 Maryland Director 79 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ţ Examiner must be notified Direct 1 ☐ Yes XX No Harford Maryland Street 5 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 23a Funeral 3824 Davis Corner Road 21154 United States items 12. Was Decedent Ever in U.S. Armed Forces? 1953 1 1 2 Yes 2 ☐ No If Yes, Give 1955 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or 1 Never Married 2 Married Completed by Maryland 21215-0036 72 hours after Specify: White 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any njury or other traumatic event, the Mea once. Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Defense Auditor Be 17. Father's Name (First, Middle, Last)

Kyle Ward James Golley 18. Mother's Name (First, Middle, Maiden Surname) Rita Bockmier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Golley / Son 10002 Nearbrook Lane Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State April 9, Burial 2 Cremation 3 Removal from State Highview Mem. GArdens 4 Donation 5 ☐ Other (Specify) 2010 Fallston, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel &
3 Newport Drive Forest Cremation Service-BelAir Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ BRONCHOPNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): rsician and burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year 2 🗌 No signed by the a d be detached f 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes Completed 2 No 3 Probably 4 Unknown ns certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy Hospital or Attending Physician: The Yes 2 X 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify, Hospital: ပ 1 Inpatient 2 K ER/Outpatient 3 IDOA this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral to 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 | 3 | only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DØ1373 QUID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USLER DRIVE MARYLAND 21204 RANCIS CARMODY M.D. 7601 TOWSON. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month A pril Physician/ JEAN ELIZABETH 1950 GREELEY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Howard County General Hospital Columbia If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year))5/23/1937 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Mary Land 577-50-8393 Director Usual Residence of Decedent 10b. County "natural", or items 23a or 28a-f sho edic I Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Prince Georges Laurel 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 405 Montgomery Street 20707 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Widowed 4X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Greeter Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Morgan Myrtle Rogers 19a. Informant's Name/Relationship (Type, Print)
Julie Greeley/Daughter-in-Law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 428 Burwood Ave., Glen Burnie, MD 21061 Department of Healt Important: If item 2 any Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) : 04/07/2010 Cremetion Service Hanover, Maryland . Signature of Funeral Service Licens 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, St.eN, Hanover, 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition SEPTIC CHOCK Medical resulting in death) Due to (or as a consequence of): Examiner VANCOUNCIN RESISTANT Sequentially list conditions, Duvi to for ea a consequence of cause. Enter Underlying Cause (Disease or iinjury Exami The law requires that the death certificate be executed RENAL CELL CARCINOMA burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Yes 2 No g 🗌 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PULMONARY EMBOLISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RENAL FAILURE 24a. Was an has autopsy performed? RESPIRATORY FAILURE this certificate Yes 2 L Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [] 3 [] the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D0043662 512010 wn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Boyce Howard 31. Date filed (Month, Day, Year) State APR Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:32 Augustus A. Hayes, 28 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Battimore Baltimoro 8. Date of Birth (Month, Day, Year) 9-11-1939 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Months 1 🖳 M 2 🗆 F Hours Director 70 GA 253-56-7900 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director MD 1 🗆 Yes 2 🔽 No Balto Windsor Mill 10g, Citizen of What Country? Funeral S 8316 Tinsley Road U 21244 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene, marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augustus A. Hayes, <u>Janette Branham</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 i Willow Grove, PA 1003 Easton Road Leigh Sk 20a. Method of Disposition Skipper-brother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4-9-2010 Owings Mills, MD March East F/H 21. Signature of Functal Service Licensee 22. Name and Address of Facility Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) reles uescelar discase Examiner Sequentially list conditions compaquarité on if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 1 ralee burial-transit Due to (or as a consequence of) resulting in death) Last lais attending physician Physician/Medical certificate be the as IF FEMALE: nse ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months? Month Dav Year Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown Division of Vital Records, P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No prior to completion of cause of death? has certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 110 1 Inpatient 2 ER/Outpatient 3 DOA 2 within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Ucertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOOR 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

APR 0 9 2010

Franchis A Have

Knownas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State Registrar		,	Cei	rtificate of	Death		Reg. N	lo. 1	0 10930
	Physici	an	1. Decedent's Name (First, Middle,	,					2. Date of De Month	D	ay Yea	3. Time of Death
	/Medic	al	Jane W. Herric						APRIL		7 201	0 0.70
	Examin	er	4a. Facility Name (If not institution,				4b. City, Town, o		ath	1	C. County of De	
	Funeral				(In yrs. la	ast birthday)	If Under 1 Year		rs. 8. Date of Bi	rth ,	9. E	Birthplace (State or Foreign
- 1	Director		091-20-1422	1 □ M 2 🔯 F	93	Yrs.	Months Days	Hours Mi	8. Date of Bi n. 01-01-	19T	7	Birthplace (State or Foreign Country) NY
	pu "		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	nation					10d. Inside City Limits
	faryla sho	5	MD Harf			el Air						1 ☐ Yes 2 ☑ No
	the N	Director	10e. Street and Number	Oru	D	er All	10f. Zip Code			10a C	Citizen of What	
	3a or		204 E Chaucher	Lane			2101	<i>/</i> .		rog. c	USA	Journay:
	death	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S	3. 13.	Was Decedent of H		(Specify Yes or N	0-	14. Race - Ar	merican Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it all which Examinating the incitied at once.	ρ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced)	1	1 □Yes 2 X No		erto Alcan, etc.)		Black, Wh	
7 5	72 h "natu	Completed	15. Decedent's (Specify only highest)	Education grade completed)		(Give	dent's Usual Occup kind of work done	during most of w	rorking	16b.	Kind of Busines	ss/Industry
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, <u>e</u>	ld be lental ked c	To Be	Maynard Stacey	Wiggins					Josephine			
Mary	shou and N s mar		19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street		-			e, Zip Code)
UZ	and 2 salth n 27 I	13	David R. Herric	k (Son)		146 D	elaware .	Ave Laui	cel, DE 1	1995	6	
H 台PPP.[Baltimore.	jes 1 t of He If iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	20b. Pl	ace of Dispo emetery, cren	sition (Name of natory or other place	ce)	Date	20c.	Location - City	or Town, State
<u>a</u>	t. Pag tmeni tant: jury		4 ☐ Donation 5 ☐ Other (Spe	cify)	Bay	view (Crematory	04-	09-2010	Bal	Ltimore	,_MD
	Depar Mpor Iny In		21. Signature of Femeral Searce Lie	nsee		22	. Name and Addre	ess of Facility So	chimunek	Fun	eral Ho	ome of BelAir
王	20240	\vdash	22g Port 1 Enter the diseases or or	maliantian that accord to	ما المحمد المحاد	1	nc 610 W	 MacPha 	nii Rd Be	elAi	r, MD 2	21014
		er s	23a. Part 1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	ly one cause on each line	١.					arrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Due to (or es e	1574	TTIC !	LUNGO	ANCEI	2			-
	Examiner			Due to (or es e	consequ	ence or).						
	П +	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ence of):						
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000	ificate be executed physician and s the burlal-transit		resulting in death) Last	Due to (or as a	consequ	ence of):						
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ğ	death a atter	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal	death 3 □	☐ Ectopic pregnand ☐ Other (specify) _	у			23d. Date of o Month	Day Year
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ecc	law ra as be 2 sh	plet	DYSLIPIDEMIA	1					24a. Was	s an opsy	24b. Were	autopsy findings available to completion of cause of
<u>~</u>	: The cate h	Con								ormed?	death	i? ′es 2□No
Vita	lclan certiff	Be	25. Was case referred to medical examiner?	I de a state			1		eath (Check only			
oto	Phys	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatien		ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing	Home 5□ Res			pecify) ASSISTED
Division of Vital Records. P.O. Box	ding h, After funer	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Day,	Year)	Injury	Wor	ryat k? Yes 2 ∐No	28d. Describe	how inj	ury occurred	LIVING
įį	Atten deat actor: by the	fica	3 ☐ Suicide 6 ☐ Could not	be 390 Place of Injur	y - At hor	me, farm, str			28f. Location	(Street	and Number or	Rural Route Number,
D.	al or safter	Certification: To	4 ☐ Homicide determine	building, etc.	(Specify)			City or To	wn, Sta	ite)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal-transit	edical (29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of amlner: On the basis of and manner state	examinat	vledge, death ion and/or in	n occurred at the ti vestigation, in my	me, date and pla	ace, and due to the courred at the time	e cause e, date a	(s) and manner and place, and c	as stated. Jue to the cause(s)
	To t To tl	M	29b. Signature and title of certifie	m			29c. Licens					onth, Day, Year)
			· Me	Gam A	1 D		DU	15344		0	4/07/	2010
	8		30. Name and address of person who SURESH DHANT	ANI MD	ath (Item	23a) (Type,	Print) DN AVE,	LAMA	= >6 000	شرع ۵	111 3	107.8
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	Registr	ar	APR 09	2010 June	1	1 1	and					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland		rtment of F tificate of D		d Mental Hyç	0.0	110	10021
			Decedent's Name (First, Middle	e, Last)			in out or E	- Outri	2. Date of Dea	Reg. No. / (1111	3. Time of Death
	Physicia Medio		ESTELLE	HARLEY					March	2 ^{Pay}	2010	1:20 P M
	Examin	er	4a. Facility Name (if not institution	,	-11-		4b. City, Town, or		ath		y of Death arles	
	Funeral		Charles County 5. Social Security Number	6. Sex 7. Age	enab (In yrs. last		If Under 1 Year	If Under 24 H		1		olace (State or Foreign
	Director		577-14-9544	1 □ M 2 🕱 F	99	Yrs.	Months Days	Hours Mi	reb. 25	, Year 911	Coun	DC DC
	nd how at	٦٢	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City Limits
	Maryla 18a-fs rtified	Director	MD Char	les l	Wa	ldorf						1 ☐ Yes 2 🛣 No
	a or 2 be no		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	th with ms 23 must	Funeral	70 Village Dr.			1,0,11	2060			USA		
ထ	or ite	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Mar	12. Was Decedent E Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \)			Yes, specify Cubar		Specify Yes or No- erto Rican, etc.)		ce - Americ ack, White,	
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yla	uld be I Ment narke	입	Henry James Ca						Montague			
Ma	2 shorth and the and the and traun		19a. Informant's Name/Relations Donna Harley -		ar		Address (Street a		Rural Route Number neltenham			Code)
ē,	1 and if Heal item other	- 1	20a. Method of Disposition		20b. Plac	ce of Dispos	ition (Name of		Date	20c. Location		own, State
<u><u>ä</u></u>	Page nent c ant: If ury or		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (atory`or other place Na ti onal		1-2010	Laurel,	MD	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Informant of Health and Mental Hygiene. Infoortant If item 27 is marked other than "natural", or items 23a or 28a-f show any hilury or other traumatic event, th. Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	113				Home of Suitlan			
I			23a. Part 1. Enter the disease, o	complications that caused	the death.						20140	Approximate Interval Between
4	Trysician/	i ii	Immediate Cause (Final disease or condition	Al	zho	im	er's	Der	nenti	CA.	- 9	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	consequer					100		
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2	uted	Examiner	Cause Enter Indert in Cause (Disease or iinjury that initiated events	С.					-			
,0	cate be executed physician and sthe burial-transit	a E	resulting in death) Last	Due to (or as a	consequer	nce of):						
200	cate by physic the b	edical		d								
88	certific inding use as	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			.			23d. Da	ate of delive	ery
gox	death ne atte ed for	Physician/M	in the past 12 months?	4 Pregnant at			Ectopic pregnance Other (specify)	4		M	onth	Day Year
o.	at the d by the etach	Phy	9 Unknown Part II. Other significant conditi		ut not result	ing in the un	derlying cause give	en in Part I.	23a Did to	bacco lise con	tribute to th	ne cause of death?
S, D	ires th signe d be c	d by					, 5		1 🗆 Y	\		pably 4 🗆 Unknown
ord	v requ	Completed							24a. Was a		Were autor	osy findings avallable
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<u> </u>	Physic this c	. To	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 Inpatie	T	R/Outpatient		4 LX Nursing	Home 5 Reside)
0 0	nding tth. : After e funer	cate	1 Natural 5 Pendi 2 Accident Investi	ng (Month, Day,		injury	28c. Injury work? M 1	at } Yes 2 □ No	28d. Describe ho	w injury occur	red	
Division of Vital Records, P.O. Box 68	r Atter	Certificate:	3 Suicide 6 Could 4 Homicide detern	not be 280 Place of Injur	ry - At home	e, farm, stree	et, factory, office		28f. Location (Si		er or Rural	Route Number,
á	oital o urs aft ral Di	-							1			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical I	Physician: To the best of r Examiner: On the basis of ex Nurse Practioner: To the b	amination a	nd/or investig	gation, in my opinio	n, death occurre	d at the time, date ar	d place, and du	ie to the cau	use(s) and manner stated.
	To the within To the comp.	2	29b. Signature and title of certifie		or my Ki		29c. License			29d. Date signe		
			7. Huss	en, 1	no		05	5455	5	3/30	110	
	9		30. Name and address of person Fatima Hussei				int) .d. #101	Camp S	prings, M	D. 207	46	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar	r's Signature	e		F	. 0-7			
	Registra		APR 0 9 201	O Sexue	1. 4	back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **0900** 2. Date of Death HILLSINGER Month O Physician/ 10 NE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Bowie 3615 Melfa Lane 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, Yea Pennsylvania 1 🗆 M 2 🗷 F Months Days Hours Min. 1916 93 Aug. Director 177-05-1996 Usual Residence of Decedent rms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 □ No Maryland Prince Georges Bowie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20715 USA 3615 Melfa Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) G.A.O. Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marv Dzedolik Frank Blank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 3615 Melfa Lane Bowie, MD 20715 Paul W. Hillsinger/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Mary land
Lerans Cemetery 1 X Burial 2 Cremation 3 Removal from State 4/12/2010 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical onsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of The law requires that the death certificate be executed use as the burial-transit Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month ō Year Day 9 Unknown detached by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be deta 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be Z Other /S Home 1 Yes 2 No Hospital 4
Nursing Home ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) iniury 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasts of examination and on investigation, in my opinion, described at the firme, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce cause of death (Item 23a) (Type, Print) what comple ENAM 32. Regis ar's Signature State

DHMH 17 Rev 7/2009

Registrar

10-02750 Yolanda Hall

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olanda Hali	1- For State		cate of Death		. No.	0 1193
Physician/	1. Decedent's Name (First, Middle,Last)	. 1		2. Date of Death	Day Year	3. Time of Death
Medical Examine	10101100	Hall		April 7, 201	0	2045 hrs
	4a. Facility Name (if not institution, give s 4008 Edgewood Avenue	treet and number)	4b. City, Town, or Location of Baltimore	Death	4c. County of Death	
Funeral	Social Security Number 6. Sex	7. Age (In yrs. last b		24Hrs. 8. Date of Birth	(MM/DD/YYYY) /9. Birt	
Director	214-68-3983 1 M	2× 52	Yrs. Months Days Hours	Min. May 2	1957 Foreig	untry) Florida
any	10a. State 10b. County	10c. City, Tov	n or Location			10d, Inside City Limits
aryland Sa-f show at once.	Ma. I NIA	r Ba	Himore			1 Yes 2 No
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	10e. Street and Number	I DI	10f, Zip Code	10g	. Citizen of What Cour	ntry?
rith the s 23a o	11. Marital Status	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Original	n? (Specify Yes or No-	14. Race - Ameri	can Indian, Black,
death v r item nust bo	1 Never Married 2 Married	Armed Forces? Yes 2 X No	If Yes, specify Cuban, Mexican,		White, etc.	(.
s after or rail", o	3 Widowed 4 Divorced If	Yes, Give Year Dates:	1 Yes 2 No specify:		Specify: B	ack
hours "natur	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	highest grade completed) 168 College (1-4 or 5+)	 Decedent's Usual Occupation (Give k during most of working life, DO NOT to 		6b. Kind of Business/1	ndustry
215-0036 be filed within 72 hours af ntal Hygiene. ked other than "natural ent, the Medical Examin Be Completed by	12	2	Technicia	, l	Air Purif	ling Co.
ID 21215-0036 should be filed within 7 and Mental Hygene. 77 is marked other than natic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last)	+	18.Mother's	Name (First, Middle, Ma	,	1
2121 tould be fill d Mental It is marked tic event, I	19a. Informant's Name/Relationship (Type	Print) In 18 11	9b. Mailing Address (Street and Numl	per or Rural Route Numb	er. City or Town, State	Zip Code)
MD 3 thou th and I are 12 is r	Mrs. Mary He	mother)	500 Bedford	Avo. 311	Balto,	Md. 21208
ore, MC es I and 2 s of Health a If item 27	20a. Method of Disposition 1 Burial 2 Cremation 3		e of Disposition (Name of cemetery, atory or other place)	/	20c. Location - City or	Town, State
Baltimore, permit. Pages I a Department of He Important: If ite	4 Departation 5 Other Specify:	M	t. Zion	4/15/2010	Lansdo	wne, Md
Baltimo permit. Page Department of Important: injury or oth	21. Signature of Funeral Service License		22. Name and Address of Facility	s Funeral	Home, P.A	
Physician	23a. Part I. Enter the bisease, or complide	ations that caused the death. Do	not enter the mode of dying, such as ca	rdiac or respiratory arres	t, shock, or heart	Approximate Interval
Examiner	failure. List only one cause on each Immediate Cause (Final disease a.	^{IINO.} Metastatic bre	ast cancer			Between Onset and Death
LAdillilei	or condition resulting in death)	e to (or as a consequence of):				
Jer Jer		e to (or as a consequence of):				
red Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e to (or as a consequence of):		_	· W ———————————————————————————————————	
ecuted and ransit	d					
60, ate be execu ohysician and te burial - tr	X UNPENDED	MENDED 23a, PII, 27, pe	r ME g903 5/3/10 T	T		
8760, ifficate being physical street burd		23c. If yes, outcome of pregnand 1 Live birth		pregnancy	23d. Date of delivery Month	lay Year
b. Box 687(the death certification of the attending placed for use as the Physician/A	past 12 months?	4 Pregnant at time of death	5 Other (Specify)			1
the death by the att	Part II. Other significant conditions	9 Unknown	ing in the underlying cause given in Par	t I 23e. Did toba	acco use contribute to	the cause of death?
P.O.					2 No 3 Prob	abiy 4 🗸 Unknown
Records, I The law requires freate has been sig page 2 should be Completed				24a. Was an		topsy findings available ompletion of cause of
ital Records ician: The law requi s certificate has been rector, page 2 should Be Complete				perform	ed? death?	
tal Reician: Ti	25. Was case referred to medical		26.Place of Death (
f Vit; Physici or this condition	1 Yes 2 No			Nursing Home 5 R		Scene
Division of Vital Records, P.O. tal or stending Physician: The law requires that the rest after death. To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach the cartification: To Be Completed by Pertification: To Be Completed by Pertification:	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28c. Injury at Work?		w injury occurred	
isior r Attend er death rrector: by the ficatic	2 Accident Investigation	28e. Place of Injury - At home,	farm, street, factory, office building, etc	. 28f. Location (Str	eet and Number or Ru	al Route Number, City
Division o spital or Attending tours after death. neral Director: After filled in by the func Certification:	3 Suicide 6 Could not be determined	(Specify)		or Town, Sta	te)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex	one) 2 Medical Examiner: 0	n the basis of examination and/o	leath occurred at the time, date and place r investigation, in my opinion, death occ			
A S S S S S	29b. Signature and title of certifier	d manner stated.	29c. License number		29d. Date signed (Mor	oth, Day, Year)
	(ambile	ul	O.C.M.E.		April 8, 2010	
	30. Name and address of person who con Laron Locke MD. Assistar) 11 Penn Street, Baltimore, MI	21201		
State	31. Date filed (Menth, Day, Year)	3. Registrar's Signature	1			
Registra	APR 0'9 2010	Deneura S.	barkel			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20 a b, per Fh G902 4/14/10 TT State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 9.494M arri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner cete ltinun 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Min. 1 M 2 D F Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Nes 2 No 7 M 520 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 2 121 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 I Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) onder Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ tarris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harris Javr King meters crematery of other place) 20c. Location - City or Town, State 20a. Method of Disposition 2010 3
Removal from State 4 ☐ Donation 5 ☐ Other (Speciff) 21. Signatur of Funeral Service Home f Facility MD226 teignts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lespiraten Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) disease within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 □ Probably 4 □ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury 5 Pending Division Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Chelsen isubstree 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April James G. Heckner 2010 6:12 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3207 Hiss Avenue Baltimore Parkville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Yea 1XXM 2 🗆 Months Hours Min. 56 220-62-4324 Director Maryland 1953 Usual Residence of Decedent shov 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f MD Baltimore Parkville 1 Yes 2 XXNo 10e. Street and Number 10f, Zip Code 5 10g. Citizen of What Country? must be Completed by Funeral 23a 3207 Hiss Avenue 21234 United States ral", or items 2 Examiner mus death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2XXNo Black White etc. 1 XXNever Married 2 Married 1 ☐ Yes If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural", 3 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sheet Metal Worker Kingsville Sheet Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Junior Heckner Margaret Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Heckner - Mother 3207 Hiss Avenue, Parkville, Maryland 21234 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans, Funeral Chapel & Cremation Services-BelAir 20c. Location - City or Town, State Date Department of H Important: If its any injury or of 4 Donation 5 Other (Specify) Appril 9, 2010 Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility **Evans Funeral Chapel**8800 **Harriord Road** l & Cremation Services Parkville, Maryland 21 Parkville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine s a consequence of) burial-transit and that initiated events resulting in death) Last or as a consequence of ed by the attending physician detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending naturalism Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, 3 Probably 2 🗌 No 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform 1 ☐ Yes 2 ☐ No Yes 2 X N 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 🗶 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending Accident 1 Yes 2 No Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

29b. Signature and title of certifier

only one

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month,

	_ 1	State Registrar				$C\epsilon$	ertificate of	f Death)	Re	g. No. 4 U	IU	10937
		1. Decedent's Nam	e (First, Middle,	Last)					2.	Date of Death		Vaca	3. Time of Death
Physicia	_	KATH	RYN 1	6	te DE	ECKER			,	Month PRIC	Day	Year	0735 A M
/Medica Examine	-	4a. Facility Name (4b. City, Town,	or Location			4c. County	of Death	
Zanine							D And	PALLST	Nu rad		2 A-L	TINORS	2
		5. Social Security N	HWEST	HOSPITA i. Sex		yrs. last birthday	1		r 24 Hrs. 8	Date of Birth			lace (State or Foreign
Funeral		217.52.29	930	1 □ M 2 🕱 F	94	Yrs.	Months Day	s Hours	Min. Se	penth10y	¥915	PID)	try)
Director	-	Usual Residence o	f Decedent										
and	-	10a. State	10b. County		100	c. City, Town or L	ocation					1	0d. Inside City Limits
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affe affe			ied 2 Marrie	d 1 ☐Yes If Yes, G	2 X No live		1 ☐ Yes 2 X N	o Specify	y:		Specif	v: Wh	ite
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S E E		19a. Informant's N	ame/Relationshi	p (Type. Print)		I .	ling Address (Stre						* .
1 and 2 Health a tem 27 is		Carol	e Gottle	eib- Da	ughtei	c 682	0 Autumn	View	Drive.	Elder	sburg,	Md 2	1784
the star of the other		20a. Method of Dis	position		2	20b. Place of Disp	osition (Name of	(aga)	Date		20c. Location		
ages ento				Removal from	State	New Cat	matory or other p hedral	nace)	4/12/2	2010	Baltim	ore,	MD
permit. Pages 1 and Department of Health Important: If item 27 any injury or other the Any injury or o	-	4 □ Donation 21. Signature of Fi	5 Other (Spe			- (200)	22 Name and Add	lress of Faci	lity				
Department of the property of		21. Signature of P	uneral Service Li	delisee /	N	1010SU S	terling	Ashtor	Schwa	h Witz	ke Fund	eral Ave C	Home of atonsville, 1228
		, , ,	17r,	ILLERY	~~~							4a, 2	Approximate
Harry .		23a. Part 1. Enter shock, or her	the disease, or o art failure. List o	omplications that nly one cause on	each line.	death. Do not e	nter the mode of d	iying, such a	is cardiac or r	espiratory arre	est,		Interval Between Onset and Death
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/Medical	- 1	resulting in death)		Due to	o (or as a co	nsequence of):							
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	ا <u>ب</u> و	Sequentially list co	nmediate	Due to	o (or as a co	nsequence of):							
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certificate be executed ding physician and se as the burial-transit	/Medical			0.									
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the d	Physiciar	1 ☐ Yes 2 9 ☐ Unknowr	1254 No 1	9 Uni		o or death o	□ Other (specify)						
hat the deby detac	문	Part II. Other signi	ificant condition	s contributing to	death hut no	at resulting in the	underlying cause	given in Parl	H.	23e. Did tot	acco use con	tribute to t	he cause of death?
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The ste h	E 0									perform	ned?	death? 1 ☐ Yes	
an: an: tiffica tor, p	Be C	25. Was case refe	rred to medical					26. Pla	ce of Death (Check only on			
/sici	0	examiner? 1 ∐ Yes 2 🛣]No	Hospital:	7 Innatient	2 ER/Outpati	ent 3 T DOA	Other: 4 🗆 I	Nursing Home	5 ☐ Reside	ence 6 □Ot	her (Speci	f _(z)
P F	H 1	27. Manner of Dea		28a. Dat	e of Injury	28b. Time		jury at /ork?		d. Describe ho			"
Affe	₽	1 Anatural 2 ☐ Accident	5 Pending investiga	,	nth, Day, Ye	ear) Injury		/ork? □Yes 2[□No				
deal deal ctor.	<u> </u>	3 Suicide	6 ☐ Could no	ot be	e of Injury -	At home, farm, s	treet, factory, offic	e	28	f. Location (St	reet and Num	ber or Run	al Route Number,
or A Direction by	Certification:	4 🗌 Homicide	determin	ned buil	ding, etc. (S	Specify)	rirodi, idolory, omo			City or Town	, State)	JOI OI FIGIC	a riodio realibor,
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To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Medical	29a. Certifier (Check only		xaminer: On the	basis of ex	amination and/or	ath occurred at the investigation, in m						
the hin 2 the nple	<u>e</u>	one)		and ma	nner stated		T 00- 1:			To	01 D-1	ad /Manth	Day Vasal
To COL	2	29b. Signature and	title of certifier				29C. LICE	ense numbei	Г	2	9d. Date signe	su (IVIONIN,	Day, Tear)
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,	t	30. Name and add			use of death	ı (Item 23a) (Type							
N		Debora	L WATS	ON FITZ	PATRIC	K M.D.	NO A	THWEST	HOSP	ITAL	5401 0	LO C	OURT ROAD
Stat	e	31. Date filed (Mo		32.	Registrar's	Signature	barker						
Registra			ADDAG	2010	Ruce	p. 19. 19	y acres						

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			1 - For State Registrar	State of Maryland /	Department of H		ntal Hygiene	2010	10938
	*		Decedent's Name (First, Middle, Last	')		2	. Date of Death		3. Time of Death
19	Physicia /Medic		DYIAN And	are Harri	od		3-12-Day	2010	12:47 A M
j.	Examin		4a. Facility Name (If not institution, give			Location of Death	4c.	County of Death	
			Holy Cross	HOSPITAL	Dilver	'Spring	YY		omery
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last b ☑M 2□F	Months Davs	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Dey, Yeer)	Country	
	Director		Usual Residence of Decedent		Yrs. 15		2-17-201	10 man	yland
	yland		10a. State 10b. County	10c. City, To	wn or Location			10d	I. Inside City Limits
	a-f st	ctor	MD P.G.	Lar	dover				1 Yes 2 No
	or 28	Oire	10e. Street and Number	1 1 01	10f. Zip Code	C.C.	10g. Citiz	zen of What Country	/?
	ath w	Funeral Director	4040 Conti	nental Place	. 201	80		14. Race - American	Indian
	ter de	nue	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Speci in, Mexican, Puerto Ric	can, etc.)	Black, White, etc	
336	urs aff	by	3 Widowed 4 Divorced	1 □ Yes 2 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: BLC	RCK
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. de thygiene. de other than "netural", or terms 23e or 28e-f show strent, tra Medical Examinar must be notified at syent, tra Medical Examinar must be notified at	Completed	15. Decedent's Edi (Specify only highest grad		a. Decedent's Usual Occup (Give kind of work done)	ation	16b. Kir	nd of Business/Indu	stry
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2	filed w Hygie ther ti		17. Father's Name (First, Middle, Last)		N/A	18. Mother's Name (First, Middle, Maiden	Sumame)	
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ore,	M O		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	come	of Disposition (Name of tery, crematory or other place	Dat	e 20c. Lo	cation - City or Town	n, State
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Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licens	emy mo117 8	22. Name and Addres	ss of Facility nry Foner	al Home	420 H S Wash-1	DC. 2000Z
	9		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Done cause on each line.	o not enter the mode of dyin	g, such as cardiac or r	espiratory arrest,	lr	oproximate nterval Between
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	3	70	Sequentially list conditions, if any, leading to immediate	b. Intraventrio		rnage			
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39)	artifica ing ph e as th	Med	IF FEMALE:						
Вох	death certifica e attending phi id for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		1	2	23d. Date of delivery Month D	v vay Year
	that the de ed by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify) _				
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of V	Physician: r this certific ral director,	၉	1 ☐ Yes 2 Z No	Hospital: 1 ☑Inpatient 2 □ ER/0		4 Nursing Home	5 Residence		
ou c	ding F th. After funer	ion	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer) 28b	Time of 28c. Injur	yat k? Yes 2 □ No	d. Describe how injur	y occurred	
Division of Vital Records,	or Attending after death. Director: After in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home,		28		d Number or Rural I	Route Number,
Ω	in the	ert	4 Homicide	building, etc. (Specify)	,,		City or Town, State)	
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	rsician: To the best of my knowled iner: On the basis of examination and manner stated.	ge, death occurred at the tir and/or investigation, in my o	ne, date and place, an pinion, death occurred	d due to the cause(s) I at the time, date and	and manner as stat d place, and due to the	ted. he cause(s)
	To th within To th compl	Me	29b. Signature and title of pertifier		29c. Licens	e number	29d. Dat	te signed (Month, De	ey, Year)
					H61	+286	3/1	2/2010	
3	lv		30. Name and address of person who of	on, MD 15	a) (Type, Print)		RO. S.	SMD.	,
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature					
	Registr	ar	APR 0.9.2	010 Deneur &	parker				

10-02630 James Hawrysch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner JAMES BRYAN HAWRYSCH April 3, 2010 April 4,2010 0855 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death St. Agnes Hospital Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9, Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Days Hours April 28, 1965 Director 214-80-1544 44 Country) Maryland 1 X M 2 F Usual Residence of Decedent ĭ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland N/A X Yes 2 No hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21226 1417 Cherry Street USA 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: <u>ک</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. If item 27 is marked other than "na ner traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Iron Worker Machinist 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shirley Jones Anatoly Hawrysch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1417 Cherry Street, Baltimore, Maryland 21226 19a. Informant's Name/Relationship (Type, Print Baltimore, MD (mother) Shirley Hawrysch If item 27 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State crematory or other place Jo 4/9/10 Glen Burnie, Maryland Glen Haven Mem. Pk. Donation 5 Other Specify 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A.
237 East Patapsco Avenue, Baltimore, Maryland 21225—1856 21. Signature of Funeral Service Licensee Kevin E Ecker 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and Medica Death Seizure disorder complicating remote brain injury Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED #2perME, G905,7/13/2010, WS 23a, PII, 27, 28a-f.per ME X UNPENDED attending physician or use as the burial g904 6/23/10 TT Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcohol use Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed ✓ Yes 2 No certificate 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other this 1 Yes 28a. Date of Injury (Month, Day, Year) After 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 1 Yes 2 No Pending Director: Fd 4/4/10 Fd 8:00am Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide unk Town, State) determined (Specify) unk Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 5, 2010 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) arke 32. Registrar's Signature

Registra

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 20[°]ÎÖ EUGENE JOSEPH SR. 3:05 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 812 Chatsworth Drive Accokeek Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 27 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. 1943 Director 578-56-3274 Nov. Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 27 is marked of the than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2X No Prince Georges Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20607 USA 812 Chatsworth Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Completed 3 Divorced 4 Divorced Black. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Training Instructor 12th METRO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental of Health and Mental fritem 27 is marked or rother traumatic ever ည Mary Alice Hull Floyd Collins Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine S. Joseph-Wife 812 Chatsworth Drive Accokeek, MD 20607 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 4-13-2010 Clinton, MD. 21. Signature of Euneral Service Licensee Marshall's Funeral Home of Maryland Suitland, MD. 20746 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians Metastatic Colon Cancer disease or condition **Medical** resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 N this certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 $mathbb{K}$ Residence 6 \square Other (Specify) Hospital 1 🗌 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury 1 X Natural 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined City or Town, State) Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 | To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Vermo MD MD 037013 04-08-2010 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington, DC 20010 MD110 Irving Street Nitin Verma,

Registrar

10-02436	
Mary John	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ry John		1- For State	tate of Maryl		artment of		and	Menta	i Hy		J	20	10	1094
Physici	an/	Registrar 1. Decedent's Name (First, Midd	lle,Last)		Tanoato or	Douth			12	F 2. Date of Dea	Reg. No. ath			3. Time of Death
dical Exami		Mary John	1							Month March 27	Day , 2010	Year		1143 hrs
		4a. Facility Name (if not institution		umber)	4	b. City, To	vn, or Lo	ocation of	Death	-		County of	Death	
		Snowden River Parkv	vay @ Oakland	Mills Road		Columb	oia				H	loward		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	_	If Under:		8. Date of Bi	rth(MM/I		9. Birth Foreign	place (State or
Director		219-79-3514	1 M 2 X F	21	Yrs.	Months	Days	Hours	Min.	03/12	2/19		Cou	^{intry)} Nigeria
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w any		10a. State 10b. County MD HOW			r, Town or Location	n								10d. Inside City Limits 1 Yes 2 X No
land f sho	tor													
r 28a	Director	10e. Street and Number 6133 Good Ht	intora B	ida		10f. Zip C	045					en of Wha		try?
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Division Hospital or Attend 24 hours after death Funeral Director:	Š	4 Homicide	rmined (Specify	Major Roa	d / Highway			_	Si	nowden Riv	er Park	way @ O	akland	Mills Ro, Columbia,
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To t With To t	Medical	29b. Signature and title of certific	and manner	stated.			icense r							h, Day, Year)
		1/200 5	Do 11	0 0			D.C.M.					ch 28, 20		
Λ,		30. Name and address of person	who completed can	use of death (Item	n 23a)			-						
71		Margarita Korell MD.	Assistant Me			nn Stree	t, Ball	timore, I	MD 21	1201				
St	ate		32, R	egistrar's Signat	il .									
Regist	trar	APR US	ZUNU Ck	asserd &	1. STOON	1-1								

			State of Maryland / D				Mental Hy	giene	0 10010
				Certi	ficate of E	Death		Reg. No. 4 U	0 10943
	Physicia Media		Decedent's Name (First, Middle, Last) BETTY JOHNSON				2. Date of De		3. Time of Death 2:30 P M
	Examir	ner	4a. Facility Name (if not institution, give street and number) 6902 FIELDCREST ROAD	4	b. City, Town, or		ith	4c. County of D	eath
	Funeral Director	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 1 M 2 1 F 72		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th 9.1	Birthplace (State or Foreign Country)
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5-0036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	ģ	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces 1 □ Yes 2 ☑ No If Yes, Give Year or Dates.	If Ye	s Decedent of Hi es, specify Cuba Yes 2 X No	n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Black, W	merican Indian, hite, etc. WHITE
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yland		ToB	17. Father's Name (First, Middle, Last) DAVID AIKEN			18. Mother's Na	ame (First, Middle,	Maiden Surname) MIRTE	NBAUM
Mar	27 is	-	1					r, City or Town, State,	Zip Code) N, DC 20005
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Ц	205 8 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not			TERSTOW	N ROAD, I	PIKESVILLE	MD 21208 Approximate
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. DOX	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hourst after death. To the Funeral Director. After this certificate has been signed by the attending a completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		ctopic pregnancy ther (specify)	y 		23d. Date of o	delivery Day Year
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ב ב	in: The lificate h		25. Was case referred to medical		26 Pla	ice of Death (Che	perfo 1 🗆 Yes	rmed? death	? /es 2 No
N La	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	utpatient :	Othe			ence 6 ☐ Other (Sp	ocify)
5	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) Inj	Time of njury	28c. Injury work?	at		ow injury occurred	в опу)
DIVISION	cal or Attenors after deat al Director. ed in by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)			Yes 2 □ No	28f. Location (S City or Tow	Street and Number or F rn, State)	Rural Route Number,
	Hospit 24 hour Funera leted fills	Medica	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do not only one) 2 Medical Examiner: On the basis of examination and/or only one) 3 Certifying Nurse Practioner: To the best of my knowledge, do not only one)	r investigat	tion, in my opinior	n, death occurred	at the time, date a	nd place, and due to th	e cause(s) and manner stated
	To the within To the comp	_	29b. Signature and title of certifier?		29c, License	number		29d Date signed (Mo)	oth Day Year)
			30. Name and address of person who completed cause of death (Item 23a) (To Camara S. Sabel, MID) 2 (Camara S. Sabel, MID) 2 (Camara S. Sabel)	Type, Print	ouds D	VIOZ A	4400 a	vies mills	71115 aus,
	Stat Registra	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	h	ake			· · · · · · · · · · · · · · · · · · ·	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month :50P М April Jerry Frank Klapka Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 42 Wagners Lane Baltimore Essex Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1933 Months Days Min. (Month. , Day, 1 XM 2 F Hours Country)
Marvland 76 Yrs. **Director** 219-28-2376 Dec Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 No MD Baltimore Essex ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 United States 42 Wagners Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Eastern Stainless d 2 should be filed with alth and Mental Hygier 27 is marked other t 10 Steel Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ James Klapka Bertha Albrect traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Paul Klapka /Son 505 Shoreline Road Carrollton, VA 23314 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 remation 3 Removal from State 0.7 Apr Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Metasta Ph, sician/ Canco tic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to miniediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year Unknown the 9 Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 2 🗆 No 2 1 N 1 Yes Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner at eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral Natural work? 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check only or 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year) April 5th. 2010 D45390 9 Name and address of person who completed cause of death (Item 23a) (Type, Print) Shibdelphia Road #208, Baltimore, MD 21237 Min (h.D. 9114 31. Date filed (Month, Day, Year) strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle Last) 3. Time of Death Month 0 4 **Physician** Keith Knopp 07 15:50 M Anthony 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** The Pines Genesis HealthCare Talbot <u>Easton</u> If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) Date of Birth (Month, Day, 1 ☑ M 2 ☐ F Months Days Hours Min. 219-78-1164 52 March Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov 1 ☐ Yes 2 ☑ No Directo Maryland Talbot Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 'natural", or items 23a or 1020 N. Washington Street 21601 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. White Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Roofer Construction is marked other Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin F. Knopp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau David K. Knopp (brother) 6473 Landing Neck Road, Easton. MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only op-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performe 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 □Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director; 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

21215-0036

Box 687608

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrars Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01^{Day} Physician/ Thelma I. Karle April 3:48 P_{M} 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2705 Burridge Road Baltimore Baltimore 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Dec. 19, 1919 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X F Country) 90 216-05-2860 Director Mary l'and permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2705 Burridge Road 21234 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No 11. Marital Status 14. Race - American Indian, Black, White, etc Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Provident Savings Bank Elementary/Seconday (0-12) College (1-4 or 5+) offiær 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Geisel Lillie Mae Kaufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Nizer/ Daughter 9502 Gunhill Circle, Baltimore, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Moretand Menorial 04/06/2010 Parkville, Maryland 4 Donation 5 Other (Specify) Park Evans Fureral Chapel & Cremation Services 8800 Harford Rd. Parkville, Maryland 21234 21. Signature of Funeral Service Licenses LMIL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADVANCED Physician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a conse vience of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ certificate has been signed by the atte rector, page 2 should be detached for in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 🗌 Yes 2 🍂 No Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) ဂ္ 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certificate: 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after de:

To the Funeral Director

completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064369 APRIL 6(Six) 2010 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8113 HARFERD RD STE 100, PARKVILLE, MD 21234 DRAGOS POPESCU NED 31. Date filed (Month, Day, Year) State 32. Registrar's signature APR 0 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4/3 2010 9:30a M J. Knighton Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3855 Greenspring Avenue Social Security Number | 6. Sex | 7. Age (I Baltimore 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F (Month, Day, Year 6/16/28 Months Days Hours Min Director 81 SC 248-34-6786 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Greenspring Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 K Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Supervisor Postal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jermit. Page 1 and 2 should be 1.
Department of Health and Mental Important: If item 27 is more any injury or other. ပ John Knighton Cora Blackmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brattle Road Baltimore, MD Roland Knighton/son 8227 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4/12/2010 Garrison Forest Donation 5 Other (Specify) Owings Mills, Signati Funeral Service License 22. Name and Address of Facility 4300 Wabash Avenue March FH-West Baltimore, MD 21215 23a. Part / Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death Unknow Part II. Other significant conditions cantributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn 1 Yes vision of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 Tes 2 🗌 No Director: / Accident Investigation Suicide
Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge eath occurred at the time, date and place, and due to the cause(s) and manner as stated within 7 29b. Signature and title of certifier h. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEI

Registrar

DHMH 17 Rev 7/2009

State

Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FLORENCE RUIH KLENDER 3. Time of Death Physician/ W:1574 M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Anne Bor nit 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 218-12-2758 1 🗆 M 2 🕱 F Months Days Min Jan. 17 Hours 87 Director Mary Land Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified Maryland Anne Arundel Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5726 Franklin Street 21225 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify. White the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Injury or other traumatic event, the Menan injury or other traumatic event, the Menan Injury or other traumatic event, the Menan Injury or other traumatic event, the Menan Injury or other traumatic event, the Menan Injury or other traumatic event, the Menan Injury or other traumatic event, the Menan Injury or other traumatic event, the Menan Injury or other traumatic event, the Menan Injury or other traumatic event the Menan Injury or other College (1-4 or 5+) Harbison Walker Co. Payroll Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alexander Vance Olive A. Kruse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Cousin) Sara Eileen Downey 723 Deering Road, Pasadena, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/8/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, 237 Fast Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year the g Unknown Unknown Division of Vital Records, P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy perform certificate 2 No Yes 2 X No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 Yo æ 26. Place of Death (Check only one) ဂ္ Other: After this of funeral dir Topatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 Yes 2 🗆 No within 24 hours after death

To the Funeral Director: completed filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29b. Signatui and tille of c 29d. Date signed (Month. Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland /				and M	ental Hy	giene)	
			Registrar		Cer	tificate of D	eath			Reg. No	.2010	10948
	Physicia	ın/	Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ath Da	y Year	3. Time of Death 4:51 PM
	Medid Examir		Nicholas S. Lator 4a. Facility Name (if not institution, give stre	re et and number)		4b. City, Town, or	Logation of	f Dooth	April			
	Examilia	lei	Union Memorial	or and harmony		Balti		Death		40	. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Year			8. Date of Birt			place (State or Foreign
	Director		216-18-3421	M 2 □ F 86	Yrs.	Months Days	Hours	Min.	(Month, Day August	$\frac{7}{28}$	1923 Ma	ryland
	nd how at	Ž	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Loc	ation						10d. Inside City Limits
	larylar la-f s ified	Director	Md. Balto.			Nottingh	om.					1 Yes 2 No
	or 28		10e. Street and Number			10f. Zip Code	am			10g. Ci	tizen of What Cou	
	with s 23a ust b	Funeral	34 Whips Lane			21236					USA	
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36	after I", or xamir	l by	1 Never Married 2 🖾 Married	1 A Yes 2 □ No		☐ Yes 2 No		T dorto T	nouri, oto.)		Black, White, Specify: Wh	etc. ite
8	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's Educa	If Yes, Give Year or Dates.4-1-1943		ant'e Heual Occupa	tion		1	401 1		
75	n 72 h an "n Medi	dm	(Specify only highest grade completed) (Give kind of work done during most of working								ling of Business in	dustry
7	withii giene eer th		Elementary/Seconday (0-12)	College (1-4 or 5+)	C1	.erk					Produ	ce
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)						(First, Middle,		Surname)	
돌	should be n and Ments 7 is marked raumatic e	-	Frank Latorre						'Antoni	_		
∑	Ith and Ith and 27 is the traur	ľ	19a. Informant's Name/Relationship (Type,			Address (Street a				-		
	and Hea tem		Maria Pistorio 20a. Method of Disposition	DTR.		bin Lynne ition (Name of	e Cou		rerry E		ocation - City or Ti	
Baltimore,	permit. Page 1 Department of I Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☒ Other (Specify E1			atory or other place of Faith		-9-2			to.Md.	, 5
alti	permit. I Departir Importa any inju once.		21. Signature of Juneral Service Lice See	1		Name and Address	1 1				neralHom	e
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289	ertifica ding p		IF FEMALE:	If yes, outcome of pregnancy								
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Vital Records,	quires en sig ould b	ted							1 □ Y	es 2	XNo 3 □ Pro	bably 4 🗆 Unknown
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Å T	The cate h	Con	-1						perfor	med? 2 X No	death?	
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01.0	Phys	<u>ن</u> کو	T LI fes 2 pa No	1 Inpatient 2 L ER/O	utpatient Time of	3 DOA 28c. Injury	4 L J Nurs		ie 5 🗌 Reside		Other (Specify)
פת	nding ath. : After e fune	cate	1 Natural 5 Pending 2 Accident Investigation		injury	work?		- 1	od. Describe no	ow injury	/ occurred	
DIVISION	- Atte	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At home, fa	arm, stree	et, factory, office		28			d Number or Rural	Route Number,
2	italor irs aft al Dir			building, etc. (Specify)					City or Town	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within Part and the forest of the section of the this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and/o	or investig	ation, in my opinion	, death occi	urred at th	ne time, date an	d place.	and due to the car	use(s) and manner stated.
	o the	Š	only one) 3 Certifying Nurse Pr 29b. Signature and title of certifier	actioner: To the best of my know	rledge, de	ath occurred at the	time, date a	nd place,	and due to the	cause(s) and manner as st	ated.
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	141	}	30. Name and address of person who comp	leted cause of death (Item 23a)	(Type, Pri		KAL		A, MD	4	5 2010	
	W' .		201 E. university	PKWY, Baltimo		md 21:						
	Stat	~	31. Date filed (Month, Day, Year)	32. Registrar's Signature								
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2010 7:30 P.M **Physician** APRIL MARGARET L. LOMBARDO /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** LIVING CARROLL SYKESVILLE HOMESTEAD AT SUN VALLEY ASSISTED If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year, 3/22/1924 . Age (In yrs. last birthday) 86 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 □XF MARYLAND 216-16-2342 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the IA-dical Examinar must be notthed at 1 ☐ Yes 2 🛣 No Director WOODBINE CARROLL MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 7035 EDEN MILL ROAD 21797 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 8TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VIOLET MCMANUS JOHN LEAHY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WOODBINE, MD 21797 7035 EDEN MILL RD. DONNA MCMANUS/NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place)
DULANEY VALLEY MEM. permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/8/2010 COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) GAPDENS 4/0/2010 122. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO217 21286 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Distast **Physician** Alzheimers disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burlal-transit Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □Yes 2 No 5 Other (specify) <u>Р</u> the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform page 1 ☐Yes 2 🗷 No 1 ☐ Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera Injury Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010 H53939 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 212 Washington Heights Med Ctr; Westminster, MD 21157 Babak Imanoe 1.00 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Virginia V. Lange 2010 2:30 P Medical April 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 703 Kevin Road Baltimore n/a if Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 1-24-1929 1 M 2 TXF Hours Min **Director** 212-44-8833 Usual Residence of Decedent or 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 703 Kevin Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: African-American Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Damestic Be rgini 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Susie Palmo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Martin Court, Apt. C, Baltimore, MD 21229 Yvonne F. Lange/Daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 4-14-2010 Metro Crematory Signature of Funeral Service Licent 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ch line. Enter the disease, or complications that Approximate Interval Between slock, or heart failure. List only one cause of a Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year signed by the all d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Investigation Could not be filled in by the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of death (Item 23a) (Type, Print) 405

Registrar DHMH 17 Rev 7/2009

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year Elizabeth Olivia Lewis 2010 8:35 <u> April</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Baltimore Center Towson 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dav. Year) **Funeral** Months Days Hours Min. 1 M 250F Director 219-03-4421 89 01/29/1921 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a fredical Examinat mint be notified a proce. Director 1 ☐ Yes 2 X No Maryland Parkville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 2610 Luiss Deane Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ②

No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes XXNo 21215-0036 Specify: \$ Specify: 3℃Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home timore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Harriett O. Lease Howard E. Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gale E. Lewis (Daughter) 2610 Luiss Deane Drive, Parkville, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1

Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gard: 04/10/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Eacility Ski Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland 21221 Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or rear failure. List only one cause on each line. Immediat ause (Final diseas r condition resulting in death) Physician /Medical Due to (or as a nsequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 No Completed 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2. 29b. Signata

State Registrar

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and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Dorothy June Larkins 10:58 A^M 6, 2010 April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, May 28, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Months Days Hours Min. 1 □ M 2 🔀 F 215-24-2369 82 Yrs Baltimore, Maryland Usual Residence of Decedent 10b. Count 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Timonium Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21093 32 Northwood Drive of America 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\subseteq Yes \) 2 \(\subseteq No \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc 1 Never Married 25 Married white 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Maryland College (1-4or 5+) File Clerk Casualty Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Lee Gildenfenney William Thomas Stanley 19a. Informant's Name/Relationship (Type. Print) Mrs. Eileen Koehler/ daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1029 Smallbrook Lane York, Pennsylvania 17403 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition April 10, More Tand Memorial ₩ Burial 2 Cremation 3 Removal from State 2010 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timenium, Maryland 21093 23a. Part 1. Ever the disease, or complication and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final sepsis disease or condition resulting in death) Due to (or as a consequence of) perforated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

law requires that the death certificate be executed burial-trar Box 68760 attending physician for use as the buria P.O. ned by the signed to of Vital Records, page 2 Physician: The certificate director this After th funeral Division Hospital or Attending death. 4 hours after death by the To the Tours are:

To the Funeral Direct

Physician

/Medical

Examiner

Funeral

Director

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marked other than

Health and Mental em 27 Is marked o

Department of Heat Important: If item 2 any Injury or other

Physician

Examiner

/Medical

Pages 1 and 2 should

Director

Funera

Completed

Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical <u>ک</u> Completed Be Certification: To Medical

Examine

1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifigi

29c. License number

29d. Date signed (Month, Day, Year)

· agothia Smano MO 20051347

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYNTHIA SOCIANO M) 670/ N. CHARLESST BULTIMOSE MO 21204 CYNTHIA

State Registrar

10-02702 Jessica Lombard	lini		oe or Print in ate of Maryla								_egib	le.		
		1- For State Registrar	ato of maryi			cate of L				.,9.0.10	Reg. N	o. 20	10	1095
Physicia	ın/	1. Decedent's Name (First, Middl	e,Last)							2. Date of Month	Death Day			3. Time of Death
Medical Examir	ıer	Jessica Lomb	pardini	ımber)		4b.	. City. To	own, or Le	ocation of Deal	April 6,	2010	4c. County of	Death	2329 hrs
		University Hospital	, 5	,			Baltim					,		
Funeral		5. Social Security Number	6. Sex	7. Age (Ir	n yrs. last bi	rthday)	If Under		If Under 24Hi				Col	nplace (State or Foreign
Director		216-23-0926	1 M 2 X F		27	Yrs.	MOTILIS	Days	riours Wil	Jan	. 22	, 1983	Ma	ryland
an y		Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town	n or Location	n							10d. Inside City Limits
Maryland 28a-f show any d at once.	٦	Maryland Balti	imore		Monk	ton								1 Yes 2 X No
10f. Zip Code									-	10g. C	itizen of Wha	t Coun	try?	
th the 23a or notifie	Funeral Director	226 Everett Ro					21					SA		
sath wi	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puert											14. Race - White,		an Indian, Black,
after de Il", or	by Fu	3 Widowed 4 Div	orced If Yes, Give Yes	2 <u>X</u>	No	1 Y	'es 2	X No	specify:			Specify:	Whi	.te
hours a	g	15. Decedent's Education (Spec			ted) 16a.				n (Give kind of OO NOT use re		16b	. Kind of Busi	ness/Ir	Idustry
36 nin 72 than "	Bet	Elementary/Secondary (0-12)	College (1	1-4 or 5+)		Owner/	/ One	erato	nr.	,		Restau	ran	t
215-0036 be filed within 7 tral Hygiene. *ked other than	Completed	17. Father's Name (First, Middle,				OWNET	ОР.		.Mother's Nam	e (First, Midd				
ID 21215-003 should be filed with and Mental Hygiene. 7 is marked other th	Be	Kenneth Actor							Tanya					
MD 21 nd 2 should I alth and Mer m 27 is mar	٤	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City Christian Lombardini Husband 226 Everett Road; Monkton, MD 2										State,	Zip Code)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	1	20a. Method of Disposition			20b. Place	of Dispositio	on (Name			Date Date		Location - C	ity or 7	own, State
MOF Pages ent of nt: If		1 Burial 2 X Cremation 3 Removal from State crematory or other place) Atlantic Crematory 4-15-2010 Glen Bur										cnie	, Maryland	
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum	- 1	1. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwah Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228											h Witzke	
Physician	4	23a. Part I. Enter the disease of complications that caused the death I/Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval												
Medical	- (failure. List only one cause	on each line. a. Pentonitis	30000 1170	4004772077	100 01107 070		ayg, oc	or do da dido	or roop, atory	411000, 01	rook, or riodit	- 19	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a											
	اة	Sequentially list conditions, if any, leading to immediate	b. Perforated Due to (or as a										-	
^	Examine	Obsease or injury that initiated	с											
mand and transit	<u> </u>	events resulting in death) Last	Due to (or as a d.	conseque	ence or):									
e exec	dical	UNPENDED	AMENDED											
760 ficate b g physi	§	IF FEMALE: 23b. Was decedent pregnant in th	e 23c. If yes,					۰.	Te-4		2:	3d. Date of de		V
Box 68760, e death certificate be ex the attending physician ed for use as the burial	ciar	past 12 months?	4 Pregn	ant at time			death r (Specii	3 <u>L</u> ∑y)	Ectopic pregn	ancy		Month Mar 29,	D: 2010	ay Year
. Bo he dea y the al	Physician/Medic	1 ✓ Yes 2 No 9 Unk Part II. Other significant conditi	9 V OIKITO		4 mat manultin	en in the cond	4 di . i		:- D-+ I	Inno Di	4 100 000			ne cause of death?
Division of Vital Records, P.O. B tal or Attending Physician: The law requires that the d rs after death. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached		Superior mesentric ar	Ĭ			ig in the ond	lenying c	ause givi	en in Fait i.	1 _			_	ibly 4 Unknown
ords, w require ts been si should b	ete									24a. W				opsy findings available
ecol he law ite has	Completed by									pe	rtopsy erformed? es 2	dea	or to co oth? Yes	mpletion of cause of
tal Rec	ğ B	25. Was case referred to medical examiner?					26		f Death (Check	لبتا				
F Vit	의	1 ✓ Yes 2 No 27. Manner of Death		npatient		Outpatient 3				ng Home 5			Other:	
ion of tending Phreath.	Ö	1 Natural 5 Pend		, Day,Year)	200.	Time of Injui	ry 20	1 Yes	at Work?	Zod. Descri	be now in	jury occurred		
Visic or Atte frer der Directo in by th	Certification:		tigation 28e. Place	e of Injury	- At home, f	arm, street, f	factory, d	office buil	ding, etc.			and Number	or Rura	al Route Number, City
Divi Hospital or 24 hours afte Funeral Dir	Se l	4 Homicide	mined (Specify)							oriow	n, State)			
	Medical		ysicîan: To the bes niner:On the basis o		_									
To the within? To the comple	Med	29b. Signature and title of certifier	and manner s		, , ,			License r				. Date signed		
		Caller	NI	/	dy)		O.C.M.	E.		Ар	ril 7, 2010		
10		30. Name and address of person	•			44 D	 Ct'	Dele:	are MD of	204				
\\\ \\ Sta	t o	Zabiullah Ali, M.D. A	Assistant Medic	gistrag's S		iirenn:	oreet,	paitim	ore, MD 21	201				
Sta Registr	1.0		0.0.2010	h		1 1	a K	1						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ thehonu Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Johns Hopkins Bayview Social Security Number **Funeral** 1 🕅 M 2 🗆 F **Director** 213-70-4419 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland Director Balto MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month 2010 1945 4b. City, Town, or Location of Death 4c. County of Death Baltimore Medica Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 9-30-1958 51 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2x No Turner Station 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 541 Main Street 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?.
1 ☐ Yes 2 💆 No Black, White, etc 1

▼ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Black If Yes, Give Year or Dates 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ntary/Seconday (0-12) College (1-4 or 5+) 12th grade Laborered <u>Various Jobs</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aaron McDonald Marion Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonin Jones-Sister 1703 Greencastle Drive Balto, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Greenmount 4-12-2010 Balto, MD 4 Donation 5 Other (Specify) March East F/H 21. Signature of Funera Service Licen-22, Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final metabolic disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, that initiated events Due to for as a consequence of: resulting in death) Last

Physician/ Medical **Examiner**

attending physician and for use as the burial-transit

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Division of Vital Records, P.O. Box 68760

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Funeral

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Completed

Be

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permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Madical Examiner must be a

3altimore, Maryland 21215-0036

23b. Was decedent pregnant

g 🗌 Unknown

1 Tes

27. Manner of Death

29a. Certifier

(Check

in the past 12 months?

2 No

IF FEMALE:

Approximate Interval Between at and Death tours 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Day Pregnant at time of death

Exami Physician/Medical þ Completed Be မ Certificate:

05 W		

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one) Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 2 No

1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 4 Homicide determined

2 X No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

23e. Did tobacco use contribute to the cause of death?

24a. Was an autonsy

Yes

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown

1 🗌 Yes

Were autopsy findings available prior to completion of cause of death?

2 🗌 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

29c. License number

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lev

AVENUE

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April 2010 3:15 PM Diane M. Matthews 6, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours (Month, Day, Year 73 Director 212-34-5423 Country) **Germany** 1936 Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 Virginia Ave. Apt. 1007 21286 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural" 3 Widowed 4 Divorced Specify. Completed White Year or Dates marked other than "natur matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e 2 Henry O. Orban Margaret Virchow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Orban /Niece Sherry 1233 Armstead Way Baltimore, MD 21205 20a. Method of Disposition Date **Apr** 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 08 4 ☐ Donation 5 ☐ Other (Specify) 2010 Beltsville, Maryland Chesapeake Crematory . Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives MO1585 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition JOE K Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed and -trar that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Day Year the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 2 🔀 1 ☐ Yes 2 ☐ No Yes **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 000 Hospital မ 1 🗌 Yes Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 1 🗌 Inpatient 2 🗌 6 Other (Sp 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident 1 🗌 Yes 2 🗆 No Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, 29a, Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, within 2 To the i only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year)

State Registrar 31. Date filed (Month.

2/204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

10-02591	
Stacey Ann	Murphy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 10956 State of Maryland / Department of Health and Mental Hygiene

Stacey Ann Murph		State of Maryland / Department I-For State Certificate		d Mental H	,,	Reg. No.		
Physician Medical Examine	1/	Decedent's Name (First, Middle,Last)			2. Date of Dea	ath Day	Year	3. Time of Death 1118 hrs
Medical Examine		Stacey Ann Murphy 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	April 2, 2		c. County of De	
		Johns Hopkins Bayview Medical Cente	Baltimore					
Funeral Director		5. Social Security Number 220.04.1732 1 M 2 F 40	yrs. If Under 1 Year Months Days					Birthplace (State or Foreign Country) MD
und show any	- 1	Usual Residence of Decedent 10a. State						10d. Inside City Limits 1 Yes 2 No
eath with the Maryland items 23a or 28a-f show ust be notified at once.	<u> </u>	10e. Street and Number 2027 Larkhall Road	10f. Zip Code 21222	2		_	izen of What Co	ountry?
P 5 E L	Lune	1 Never Married 2 Married Armed Forces? 1 Yes No	Was Decedent of His If Yes, specify Cuban Yes 2 No	n, Mexican, Puerto		ĺ	14. Race - Am White, etc. Specify: Wh	
136 thin 72 hours : than "natur: edical Exami	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupati ig most of working life. e Maker			1	Kind of Busines	
21215-0036 uld be filed within 7 Mental Hygiene. Marked other than c event, the Medical	8	17. Father's Name (First, Middle, Last) Dennis Sigai		18.Mother's Name Patric	ia Fi	she	er	
AD 21 2 should h and Me 27 is ma imatic ev	9	19a. Informant's Name/Relationship (Type, Print) 19b. Ma Donald Manley/Partner 202	illing Address (Stree 27 Larkh	et and Number or 1 nall Rd				
Baltimore, MD permit. Pages I and 2 sho permitent of Health and Important: If item 27 is injury or other traumati.	Ī	1 Burial 2 Cremation 3 Removal from State crematory o	sposition (Name of centrother place) eake Cren		Date . 0 7 . 1 0		Location - City	or Town, State
Baltin permit. P Departme Importar		21 Signature of Funeral Service Licensee . M01443 2		of FacilityCAF	A/Step	her	D. L	ohrmann,PA
Physician /Medical	-	23a. Party. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line. Immediate Cause (Final disease a. Fentany 1 and methad	er the mode of dying,	such as cardiac o				Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,	one theon.	20002011				
msit Examine	all le	if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):						1
and transit	₽ -	d						
'60, ate be execut obysician and burial - tran		AMENDED 23a, 27, 28a-f, per 23c, If ves. outcome of pregnancy	ME G902 4,	/26/10 T	T	Loo	1 Date of delive	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	ysiciallyn	35. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown 23. If yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of pregnant yes, butcome of yes, butc	Fetal death 3 [Other (Specify)	Ectopic pregna		230	Month	Day Year
P.O. Es that the gned by the e detached	3	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause gi	iven in Part I.		_		o the cause of death?
Vital Records, grician: The law requires this certificate has been significated, page 2 should be Gompleted	nandini				24a. Was autor perfo	osy rm <u>ed</u> ?	prior to death?	
tal Rection: The certificate ector, page	บ - 3	25. Was case referred to medical examiner?		of Death (Check		2 140	<u> </u>	Tes 2 NO
Physic ral dire	٤L	1 ✓ Yes 2 No No Inospital 1 ✓ Inpatient 2 ER/Outpatient		Other Mursin	g Home 5			er:
ion of ttending Pleath. tor: After the funeral		1 Natural 5 Pending (Month, Day, Year)		es 2 📉 No	unk	now mga	ry occurred	
Division of a Division of a To the Hospital or Attending Physicial 24 hours after death. To the Funeral Director: After to completely filled in by the funeral edical Certification: Tedical Certification: T		3 Suicide 6 X Could not be determined Specify) residence		uilding, etc.	28f. Location (Sor Town, Sor Dundal	Street a State)2(k , N	nd Number or R)27 Lar! 4D	Rural Route Number, City khall Rd
To the Hos within 24 h To the Fur completely		29a. Certifier Check only 2 Certifying Physician: To the best of my knowledge, death ocone) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.				and pla	ce, and due to t	the cause(s)
		29b. Signature and title of certifier	29c. License O.C.M				Date signed <i>(M</i> I 3, 2010	onth, Day, Year)
okaena	3	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Pe	enn Street, Baltir		201			
State	`	11. Date filed (Month, Day, Year) 32. Registrar's Signature					····	
Registra DHMH 17 Rev 1/2001		APR 0 9 2010 Server B. A. ORIGIN	NAL.		-		OCME	
OCME 2006								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death leromes. Mc Manus Physician/ 2010 1319 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Manyland Balhmore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Mary Land 1 [XM 2 □ F Months Hours Min Director 215-28-0870 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 K No Md Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18 Lovett Court 21093 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?

X Yes 2 No Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates. Korea Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify. 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Vice President Research & Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) ပ .Tames Τ. McManus Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. McManus/Wife 18 Lovett Court Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4/12/10 Towson. Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licens 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cervical Spine Physician/ Frachere disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Collision Motor vehicle Securatelly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINE Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit ardiac Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at MOHOY 28d. Describe how injury occurred 1 🔲 Natural 5 Pending vehicl 3/31/200 1900M 1 Yes 2 No Cardiac Arrest preceding collista 2 Accident Investigation 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specific)

Store Farking Lot 28f. Location (Street and Number or Rural Route Number, City or Town, State) Cockey Sville, 9901 York Rd MD 21036 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Conflicting Number Pranticipant To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Conflicting Number Pranticipant To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Conflicting Number Pranticipant To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Conflicting Number Pranticipant To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Conflicting Number Pranticipant To the basis of examination and/or investigation. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

egistrar's Signat

22. S. Greene St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WELLS

29c. License number

Baltmore

4-10-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2010 Month Maggie Fulton McBride March 26 12:40 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Sept. 17, 1928 1 □ M 2 🕱 F Hours Min. 176-26-6150 South Carolina Director 81 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Glen Dale 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10021 Martin Avenue 20769 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Statue 14. Race - American Indian, Armed Forces? permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or is any injury or other traumatic event, the Medical Examinone. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Tillman Fulton Mattie Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvette G. McBride (Daughter) 10021 Martin Ave., Glen Dale, MD 20769 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) St. Mary Cemetery Apr.2,2010 4 Donation 5 Other (Specify) Salters, SC 21. Signature of Funeral Service Licensee ^{22, Name and Address of Facility} Henryhand Funeral Home 1951 Thurgood Marshall 29556 Ant l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Days disease or condition Complications of Cancer Medical resulting in death) **Examiner** Atherosclerotic Cardiovascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 XNo Ď Pregnant at time of death
Unknown Dav Year per the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ី Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 🛣 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 2 🛚 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at hours after death. Ineral Director: After 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

DHMH 17 Rev 7/2009

and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500

32. Registrar's Signature

Layno.

Raymond White,

31. Date filed (Month, Day, Year)

29c. License number

D0043539

Forest Glen Rd., Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

March 26, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 **Physician** Antonio Mireles April 6, 12:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 110 Choice Ct. Queen Anne's Queenstown Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** t**x**□M 2□F Months Days Hours Min. Director 97 Mexico 196-09**-**31₅1 Jan.12,1913 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Queen Anne's Queenstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ann of Health and Mental Hygiene.

It it item 27 is marked other than "natural", or items 23a or usy or other traumatic event, it is the property of the present of the 110 Choice Court 21658 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1⊠Yes 2∏No 2 Specify: Mexican Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Steel Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Trinidad Mireles ပ Dominga Orozco 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Hartman/Daughter 110 Choice Court, Queenstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
SS Simon & Jude
Cemeterv 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Apr.10,2010 Blairsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serme Licensee 22. Name and Address of Facility James F. Ferguson Funeral Home 25 West Market, Blairsville, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** isease or condition resulting in death))ebi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated eve resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by grothy Roid 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

or Attending Physician: The law requires that the death certificate be executed burial-trar and P.O. Box 68760, physician the ned by the a Division of Vital Records, has page 2 certificate hours after death.

Ineral Director: After this

y filled in by the funeral di this Hospitai 24 hours a Funeral I To the within 2

the Maryland

Baltimore, Maryland 21215-0036

Medical

State Registrar

ALERIE 31. Date filed (Month, Day,

29b. Signature and the of certifier

H0057921

29d. Date signed (Month, Day, Year) 2010

30. Name and address of person w

2540 Centreulle Road, Contreulle, MD 21617 32. Regis

nanner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:15p^M Frances Mentlik /Medical 5,2010 4c. County of Death April4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Riverview Nursing Home Essex, MD Baltimore 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 214-38-2862 6. Sex **Funeral** Months Days Hours Min 2/13/1912 98 1 □ M 2 13 F **Director** Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinant is a rectified at 1X Yes 2 ☐ No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 134 N.East Ave 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Night Supervisor House of Good Sheppard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Wilke ပ္ Mary Pabst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Trentler 314 St. George Rd Essex MD 21221
of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04-09-10 Raltimore MD 4 Donation 5 Other (Specify) Bohemian National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Nottingham,MD 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2003 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an has autopsy performed 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 | Yes 2 | 1√10 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. FORK LOK 1124 Mace John 32. Registrar's Signature 31. Date filed (Month, Day, Year)

and manner stated.

Denve S. Jack

29c. License number H 35 5 9 3

Ave., Ba Himore

29d. Date signed (Month, Day, Year)

-010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04-06-2010 **Physician** M 2250 Frances E. Maxwell /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 0 Month Day, Year, 0 2 7 - 1 9 2 4 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min MD 85 218-12-4622 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiens. Department of Heath and Mental Hygiens I have 123 or 28a-f show Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprinter must be notified at Director 1 ☐ Yes 2 🔀 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 300 Sunflower Drive #246 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify 2 Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maxwell, Frances Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Ward Bertha Ward ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Maxwell, Jr. (Son) 50 Rocky Shore Drive Orrington Maine 04474 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Morland Mem. Park 04-10-2010 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home of BelAir Ca Inc 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Malia **Physician** Cura Jusion WEEKS disease or condition resulting in death) Due to (or a /Medical Un Known **Examiner** Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi P.O. Box 68760 Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, \$ 1 X Yes 2 No 3 Probably 4 Unknown nis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28a. 28b. Time of 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated To the within 2 NNENNA UCHENDU 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010

5 State

NNENNA

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Registrar DHMH 17 Rev 1/2001 UPPER CHESAPEAKE DR BEL AIR MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		- For State Registrar				Certificate	of L	Death				Reg. No	. 401	Uit	170	
Physician Medical Examine	1	1. Decedent's Nam		le,Last) ncis Mi	ntu	cn				2	Date of D. Month April 6,	Day	Year	3. Time of D 1735 hr		
		4a. Facility Name (915 Virginia		on, give street ar	d number)		. City, Town, or Essex	Location	of Death			lc. County of D Baltimore (
Funeral	7	5. Social Security N		6. Sex	7. A	ge (In yrs. last birthda	/)	If Under 1 Yea	_	er 24Hrs.	8. Date of	Birth (MN	WDD/YYYY) 9	Birthplace (State Country)	or Foreigr	
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any	-	10a. State	10b. County			10c. City, Town or L	ocation	1	_					10d. Inside (
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la V		30. Name and addr Zabiullah Al		who completed Assistant Me			enn :	Street, Balt	imore !	MD 2120)1					
State	~	31. Date filed (Mon	th, Day, Year)	33		n's Signature		50040		= 120		·····				
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Registrar DHMH 17 Rev 1/2001 OCME 2006

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year 12:30 PM Stephen G. Maxwell 04 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Hours Min. (Month, Day, Director 216-62-1010 MD /31/55 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Baltimore MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8710 Emge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ģ 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Office <u>Administrative</u> Assistant yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Amelia Taylor James Maxwell Department of Health and Important: If item 27 is m any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 431 Notre Dame LN #12 Baltimore, MD 21234 Amelia Taylor/mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/12/2010 Baltimore, MD Zion Cem. Donation 5 Other (Specify) 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Avenue Baltimore, MD 212 FH-West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ANOXIC BRAIN disease or condition resulting in death) INJURY Medical Due to (or as a consequence of): Examiner HYPOGLYCEMIA Sequentially list conditions, Examiner Due to (or as a sonsequence on): cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical FOOT Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

DISEASE, SEVERE RENAL MELLITUS, PERIPHERAL 11AG1: 11 AQ DISEASE

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 21 No Yes 2 No 26. Place of Death (Check only one)

113000 CHT
25. Was case referred to medical examiner? 1 Yes 2 No
27. Manner of Death

1 Natural

(Check

only one)

Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 5 Pending

Hospital

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 \(\text{Yes} \quad 2 \(\text{No} \)

28d. Describe how injury occurred

3 ☐ Suicide 4 ☐ Homicid	6 Could not be determined
29a. Certifier	1 Certifying Phys

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f, Location (Street and Number or Rural Route Number,

b.	Signature and title of certifi	er
	►CB-	MI

AROLINE

29c. License number RESOOO 29d. Date signed (Month, Day, Year) 04 104

MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAYEN BLYD, BALTIMORE DSOUZA

State Registrar

Completed by

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Certificate:

32. Registrar's Signature

, 5601

Hospital or Attending Physician: The

24 hours after death. Funeral Director: A

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STEPH

MAXI

10-02737 Michael MacLeod

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		I- For State	(•	te of Deat				g. No.	201	0 1098
Physician	n/	Decedent's Name (First, Middle,Las				Date of Death Month	Day	Year	3. Time of Death 1243 hrs		
ledical Examin		Michael 4a. Facility Name (if not institution, give	MacLeod e street and number)		4b. Citv.	Town, or Location of		\pril 7, 20'		County of Death	1245 1115
1		2537 North Howard Street			Baltin					N/A	
Funeral Director		5. Social Security Number 6. Social Security Number 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	7. Age (In y	yrs. last birth	day) If Und Month		Min. 0	Date of Birth Ct. Ct.		Foreign	hplace (State or n untry) MD
yna	- 1-	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town o	or Location						10d. Inside City Limits
8	_	MD N/A	I	Balti	more						1X Yes 2 No
the Maryland a or 28a-f show tiffed at once.	Director	10e Street and Number 2537 North Ho	oward St.		10f. Zip	Code 21218		10	g. Citizer	n of What Coun	try?
and 2 should be filed within 72 hours after death with the Maryland steath and Mental Hygiene. teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married	1 Yes 21 N		If Yes, specif	nt of Hispanic Orig y Cuban, Mexican				White, etc.	can Indian, Black,
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215-0036 be filed within 7 ntal Hygiene. ked other than ent, the Medica	탉	17. Father's Name (First, Middle, Last) William Ma	cLeod			18.Mother Wand		rst, Middle, M		irname)	
212' Muld be Mental marke	음 으	19a. Informant's Name/Relationship (T		19b.	Mailing Address	(Street and Num				or Town, State,	Zip Code)
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Vita vysician this cer	ě		lospital: 1 Inpatient 2	ER/Ou		Other	Nursing H		Residenc	e 6 🗹 Other:	Scene
n of	5	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. T	ime of Injury	28c. Injury at Work	. 1	d. Describe h nk	ow injury	occurred	
VISIOR or Attend firer death Director: in by the	cati	2 Accident Investigati	28e Place of Injury -		at noon m, street, factory				treet and	Number or Rur	al Route Number, City
Div pital or ours after neral Dis	Certification:	3 Suicide 6 S Could not determine	be		residend			or Town, St. 1timor	ate½ 5		oward St
	ल्र		an: To the best of my know On the basis of examinational manner stated.								
F # F 8	ĕ∣	29b Signature and title of certifier	0/11.	Most	290	C M F				ite signed (Mon	th, Day, Year)
	-	30. Name and address of person who	Weller	Item 232)		O.C.M.E.			Whill (8, 2010 	
		Victor Weedn MD JD A	ssistant Medical Exa	miner	111 Penn St	reet, Baltimore	e, MD 21	201			
Sta Registr		31. Date filed (Month, Day, Year) APR 0 9 201	32 Registrar's Sig		barker						

DHMH 17 Rev 1/2001 OCME 2006

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State
Registrar

DHMH 17 Rev 1/2001

State 31. Date filed (

31. Date filed (Month, Day, Year)

Douglas

PINTO, MD 3421

DD 0 0040

32. Registrar's Signature

ORIGINAL

Benson Auc., Baltimore, MD 21227

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ John 101.00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richie House Baltimore N/A 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months 218-46-2163 Maryland Director 57 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3806 Elkader Road 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give 1 🛚 Never Married 2 🗆 Married Completed by 1 Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Stenographer 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Balto. City Police Dept Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George B. Nizer, Sr. Theresa E. Schleupner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Dulin Clark Road Centreville, Maryland 21617 <u> John Nizer / Brother</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4/12/2010 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21204 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 1 Yes 2 g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Deal 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director; Af completed filled in by the fu Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or inventioning the manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AV. Balt MD 21201 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State		State	of Mary	yland					lental Hy	giene	001	n	1000	
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parting.	Medic Examin		4a. Facility Name (if						4b, City, Town	, or Loca	tion of Death	04 01	_	. County of E	Death	1300	
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	Funeral	24	5. Social Security No		ex XIM2□F	7. Age (In	-		If Under 1 Ye		nder 24 Hrs. urs Min.	8. Date of Bir	th	9.	Birthp	lace (State or Foreign	
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215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than "natural", or items 23e or 28a-f sho the Medical Examiner must be notified at	Completed	3 Widowed	4 Divorced 15. Decedent's E	Year or D								,—				
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	filed v al Hyg d othe vent,		17. Father's Name (i	First, Middle, Last)				-		18. !	Mother's Name	e (First, Middle,	Maiden :	Surname)			
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2010 Maryland	should n and Me 7 is mar raumati	1	19a. Informant's Na		., , ,	,								ty or Town, State, Zip Code)			
	and 2 Health tem 27		Sue Nett		aughte	nughter) 10174 Maxine St Ellicott City, M								01.11			
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4 1 Saltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) Arlington Nat. Cem. 04-28, 2010 Arlington Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral														
Bal	permit. Departn Importa any inju		21, Sixt, ture of Full	Perus Service Licen:	Rive	Re	· ·					Rd Be					
			23a. Part 1. Enter t shock, or hear	he disease, or com rt failure. List only o	plications that ne cause on e	caused the	e death. I	Do not enter	the mode of o	dying, suc	ch as cardiac o	r respiratory ar	rest,			Approximate Interval Between	
James,	Physician/	8 3	Immediate Cause (disease or condition		· Myo	caso	dial	Inf	arctio	200					31	Onset and Death	
	Medical Examiner		resulting in death)	•		o (or as a co										•	
		e	Sequentially list co	nditions,	b. Due to	o (or as a co	nsegueñ	ice off:							+		
4	ed ed	min	cause, Enter Unique Cause (Disease or	linjury	Ducto	7 (0) 43 4 00	onsequen	100 01).							ı.		
CADA.	cate be executed physician and sthe burial-transit	edical Examin	that initiated event resulting in death) I	s 🔳	c. Due to	o (or as a co	onsequen	ice of):						 -	\top		
45.00	e be e ysicia e buri	ical		L	l d										_		
727 6876	ifficate ng phy as th		IF FEMALE:														
245 0x 687	h cert tendir rr use	ian/	23b. Was decedent in the past 12 i			e Birth 2 🗓	☐ Fetal d	leath 3 🗌	Ectopic pregr	ancy				23d. Date of Month		ery Day Year	
β 8	deat the at ned fo	/sic	1 Yes 2 Duknown	□No	4 ∐ Pre 9 ☐ Unl	gnant at tin known	ne of dea	ath 5∐	Other (specify	")				MONTH		Day Teal	
© 0.	ician: The law requires that the death certifica certificate has been signed by the attending prector, page 2 should be detached for use as	by Physician/M	Part II. Other signif		ontributing to	death but r	not result	ing in the un	derlying cause	e given in	Part I.	23e. Did t	obacco u	use contribut	te to th	e cause of death?	
S, F	signe d be											1 🗆	Yes 2	□ No 3[☐ Prob	pably 4 Unknown	
D 5	requ been shoul	Completed										24a. Was		24b. Were	e autor	osy findings available	
ford Record	ne law e has age 2	dwo										auto perfo 1 Yes	ormed?	deat	th?	mpletion of cause of	
\sim	an: The tifficat tor, pa	Be C	25. Was case referre	ed to medical					26	i. Place o	f Death (Check			0 1	162	2 🗆 110	
Vital	nysici iis cer direc	To B	examiner? 1 Yes 2	□No	Hospital: 1 □	Inpatient	2, EF	R/Outpatient	3 □ DOA	Other: 4	☐ Nursing Ho	me 5 🗆 Resi	dence 6	6 ☐ Other (S	Specify)	
C. p	ng Ph fter th ineral		27. Manner of Deatl	h 5 Pending	28a. Date (Mo	e of injury nth, Day, Ye		Bb. Time of injury	V	njury at vork?	1	28d. Describe I	how injur	y occurred			
5 6	tendi Jeath. tor: A the fu	ifica	2 Accident 3 Suicide	Investigatio	00	61.5					2 🗆 No	0011				Dest Markey	
+ letor Division	l or At after d Direc	Certificate:	4 Homicide	determined		ding, etc. (S		e, iarm, stree	et, factory, offi	ce		City or Tou			r Hurai	Route Number,	
JEH PETO Division	To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-fram.	Medical	29a. Certifier 1	Certifying Phy	sician: To the	best of my	knowled	lge, death o	cured at the t	ime, date	and place, an	d due to the ca	ause(s) an	nd manner a	s state	d.	
2	he Hc in 24 he Fu ipleter	Med	only one) 3	Certifying Nur												use(s) and manner stated ated.	
	To the Common Co		29b. Signature and	title of certifier						ense num			29d. Da	te signed (M		Oay, Year)	
			1	1	MD				_		3130		HP	rill			
	10		30. Name and addr Henry Su	ess of person who	completed cau	use of death	n (Item 2:	3a) (Type, Pr	rive si	vite.	209 B	iltimo	ren	ND 2	12	37	
	Stat Registra		31. Date filed (Mont			Fegistrar's			arkel								
								<u> </u>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Apri Orris 10:50 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OWSON more Security Numbe . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Month, Day Year) 1916 Months 1 M 2 W 9 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Ves 2 No Tomore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or than "natural", or items 23a or the Medical Examiner must be Funeral 2121 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: ack 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Rusiness Industry (Give kind of work done during most of working Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me ife. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) smestic Be 17. Father's Name (First, Middle, Last) ٩ Page 1 and 2 should be nent of Health and Ments 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -daughta ddle Mes Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying uch as cardiac or respi Approximate nterval Between Inset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or a a consequence of): certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, i 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: |2 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

MUN

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UNISON MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mr Uzg

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:45 AM April 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13 al Izabeth timore enter If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye March 30 Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours Country) .^a1918 Director 471-09-4149 92 Minnesota Usual Residence of Decedent show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Sa or 28a-f sh Maryland Ellicott City 1 Yes 2 XNo Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? as 23a or er must b Funeral 21042 USA 3114 Nestling Pine Court or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 ☑ Widowed 4 ☐ Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unit Sales Leader Home Products 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Mae Hurd John E. Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3114 Nestling Pine Court, Ellicott City, MD. 21042 Thomas Opitz son Department of Health Important: If item 27 any Injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 10, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dundalk, Maryland Sacred Heart of Jesus Cem. 2010 Signature of Funeral Service Licensee Funeral Home Of Dundalk, P.A. Connelly 21222 7110 Sollers Point Road, Dundalk, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death, bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earn line. Immediate Cause (Final oreXI Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner mellitus ears Sequentially list conditions, many, leading to in reduct cause. Enter Underlying Cause (Disease or linjury Exami eavs the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed 5 that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical ears Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 1 Yes No Pregnant at time of death 5 Other (specify) 9 Unknown detached ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nally 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30, Name and address of person who complete e of death (Item 23a) (Type, Print) Itimore 0 venue

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7, PM Piskor 2010 1:10 April Roxanna 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dundalk Baltimore 6742 Danville Avenue 9. Birthplace (State or Foreign Country) New Hampshire 8. Date of Birth (Month, Day, Year) August 21, 1925 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days Months Hours 1 ☐ M 27 F 001-20-2736 84 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 6742 Danville Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins Hospital 3 years Nurse 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ione Bailey John Cox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 Bay Avenue, Essex, Maryland 21221 Judy Celmer Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 10. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Of Mary Cem. 2010 Dundalk, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, o shock, or heart failure. Lis complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final vol 1000 disease or condition resulting in death) Due to (or as a consequence of): oromar Due to (or as a consequence of): 23d. Date of delivery death 3 Ectopic pregnancy Month Day Year death 5 Other (specify) 1 Tyes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

attending physician and for use as the burial-trai

certificate has been signed by the rector, page 2 should be detached

funeral director,

After this

24 hours after death Funeral Director: filled in by the

within 24 hor To the Fune completely fi

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 s Department of Health an Important; If item 27 is any Injury or other trau once.

Physician

/Medical

Examiner

Director

Funeral

à

Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant; If item 27 is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, It which a facility or an unit to must have a second to the traumatic event, It which a facility or an analysis of the traumatic event, It which a facility or a second to the traumatic event, It which a second to the traumatic event, It which a second to the traumatic event, It which a second to the traumatic event, It which a second to the traumatic event, It which a second to the traumatic event, It which a second to the traumatic event.

Baltimore, Maryland 21215-0036

Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

\$

Completed

Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

25. Was case referred to medical examiner 1 ∐Yes 2 1 No

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one)

27. Mangér of Death 1 Matural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Thomicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a, Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier anon

APR 09

29c. License number

29d. Date signed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Campbell Bevd, Baltimore Mt 21236 MI 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

Malinda Plumho			or Print in Black In of Maryland / Depa Ce		Health and Mental	Hygiene Re	eg. No. 2011	0 1097			
Physicia	an/	1. Decedent's Name (First, Middle,Las	t) lumhoff-Carrol	1		2. Date of Death Month April 6, 20	Day Year	3. Time of Death 0655 hrs			
Medical Exami	ner	4a. Facility Name (if not institution, giv			b. City, Town, or Location of D	4c. County of Death					
		Baltimore Washington Me	dical Center		Glen Burnie		Anne Arundel				
Funeral Director		5. Social Security Number 6. Social Security Number 1.212-11-3460	7. Age (In yrs.	last birthday) 24 Yrs	Months Days Hours	4Hrs. 8. Date of Birt Min. 09/18	Foreig	thplace (State or in untry) MD			
,		Usual Residence of Decedent 10a, State 10b, County	In Cib	. Town or Locati	00			10d. Inside City Limits			
iow any		Maryland Anne A		, TOWITO LOCAL	Glen Bur	nio		1 Yes 2 XNo			
arylane 8a-f st	Director	10e. Street and Number	I dilaci		10f. Zip Code		ng. Citizen of What Cour	ntry?			
r death with the Maryland or items 23a or 28a-f show must be notified at once.		7995 Nolpalk Cou	rt Apt.#301		21061		USA				
h with ems 23 i be no	Funeral	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent Ever in U Armed Forces?		s Decedent of Hispanic Origin?		14. Race - Ameri White, etc.	can Indian, Black,			
er deat , or ite			1 Yes 2 No	1	Yes 2 X No specify:		Specify: W	nite			
urs aft. tural" amine	d by	15. Decedent's Education (Specify or	or Dates:		t's Usual Occupation (Give kind		16b. Kind of Business/l				
6 72 hor nn "na cal Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working life. DO NOT use	e retired)					
003(within piene. Ier tha Medic	duc	12 17. Father's Name (First, Middle, Last)	3	<u> </u>	Homemaker	ame (First, Middle, M	House	hold			
e filed al Hyg	Be C		mhoff		Linda						
212 ould be 1 Ment i mark ic ever	일	19a. Informant's Name/Relationship (T	ype, Print)								
MD id 2 sh of 2 sh of 2 sh of 27 is		Neil Carroll	(spouse)		Nolpalk Court,	_	Glen Burni 20c. Location - City or				
of Hea		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	crematory or oth	· · ·	Date pril 09	20c. Location - City or	Town, State			
Ealtimore, MD 21215-0036 ournit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Internat: If them 27 is marked other than "natural", or items 23a or 28a-f shouly or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify 21. Signature of Funeral Service Licer			natory Inc.	2010	Baltimore,	Maryland			
Ball Permi		21. Signable of Therai de vice Licer	,	3	111 Mountain R	Stalling load, Pasa	s Funeral H dena, MD 21	ome, P.A. 122			
Physician		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	olications that caused the death	n. Do not enter th	ne mode of dying, such as card t cell reactio	ac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner		Immediate Cause (Final diseas a.	complicated b	y right				phy Death			
/			Due to (or as a consequence of	of):							
	Jer	Sequentially list conditions,	Due to (or as a consequence	of):							
	xamin	(Disease or injury that initiated C.	Due to (or as a consequence of	of):				V			
executed ian and ial - transit	Ш	d.									
e be execute	dica	X UNPENDED	AMENDED 27, per N	1E g904	6/18/10 TT						
Box 68760, ce death certificate be execute the attending physician and ed for use as the burial - tran	an/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pres	gnancy	al death 3 Ectopic pro	egnancy	23d. Date of delivery Month	/ Day Year			
x 6. th cert	sicia	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of d	ooth -	ner (Specify)						
. Bc the dea y the a	Phys	Part II. Other significant conditions	9 OIRIOWII	resulting in the u	nderlying cause given in Part I	23e. Did to	bacco use contribute to	the cause of death?			
P.O. es that the	ğ		John Dating to John Dating		,g		2 No 3 Prob	pably 4 🗹 Unknown			
rds, require been si	eted					24a. Was a		topsy findings available completion of cause of			
€COI ne law te has l ge 2 sl	ompleted				-	perform	med? death?				
of Vital Records, P.O. Bo) ing Physician: The law requires that the deatl After this certificate has been signed by the att tuneral director, page 2 should be detached for	ပ	25. Was case referred to medical			26.Place of Death (Ch						
Vita hysici this c	To B	Tes 2 No	lospital: 1 🗸 Inpatient 2	ER/Outpatient			Residence 6 Other				
n of ding Ph	ü	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of I	njury 28c. Injury at Work?		now injury occurred				
Division of Vital Records, tall or Attending Physician: The law require at feet death. After this certificate has been siled in by the funeral director, page 2 should it.	ication:	2 Accident Investigati	29a Diace of Injune Ath	nome, farm, stree	et, factory, office building, etc.		Street and Number or Ru	ral Route Number, City			
Division pital or Atten ours after death erral Director: filled in by the	ertifi	3 Suicide 6 Could not determine	be	,		or Town, St					
Division of Vital Records, P.O. Box 68760, of the Hospital or Attending Physician: The law requires that the death certificate be of the Funeral Director: After this certificate has been signed by the attending physici ompletely filled in by the funeral director, page 2 should be detached for use as the buri	0	29a. Certifier 1 Certifying Physic	ian: To the best of my knowled	-							
Fo the vithin Fo the	edical	one) 2 Medical Examine	r:On the basis of examination a and manner stated.	and/or investigat	ion, in my opinion, death occuri	red at the time, date a	and place, and due to th	e cause(s)			

State 31. Date filed (Month, Day, Year)
Registrar APR (19 2011)

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause by death (Item 23a)

Theodore M. King, Jr., MD.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OOME

29d. Date signed (Month, Day, Year)

April 7, 2010

10-02306	
Patricia Rayford	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	F	Reg. No.			
Physicia	an/	Decedent's Name (First, Middle,Last)	2. Date of Dea Month	Day Year	3. Time of Death		
ledical Exami	ner	Patricia Rayford	March 22	, 2010	0838 hrs		
•		4a. Facility Name (if not institution, give street and number) 2440 N. Charles Street 4b. City, Town, or Location of D Baltimore	eath	4c. County of E	eath		
Funeral Director		5. Social Security Number 2.17-90-9992 6. Sex 1 Months Days Hours 47 Yrs. 6. Sex 1 Months Days Hours	9.4im		a. Birthplace (State or oreign Country) N.C.		
,	ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
ow any					1 Yes 2 No		
Maryland 28a-f show 1 at once.	흱	MD na Baltimore 10e. Street and Number 10f. Zip Code		10g. Citizen of What	21		
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho rent, the Medical Examiner must be notified at once.	Director	2440 N. Charles Street Apt 17		U S	A		
th with	eral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		o- 14. Race - A White, e	merican Indian, Black, tc.		
fter dea	y Fun	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify:	WHITE		
nours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Busin	ess/Industry		
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade na Disabled		Disa	bled		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	S		lame (First, Middle,	Maiden Surname)			
1215 Id be fill Aental H narked event, t	Be	Warren Wroten Dor	othy Bo	ze <u>k</u>			
D 21 should and Mer is man	۵	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number					
nore, MD 21215-00. ges I and 2 should be filed with nt of Health and Mental Hygiene t: If item 27 is marked other ti other fraumatic event, the Mec	ŀ	Arthur Rayford_Husband 2440 N. Charle 20a Method of Disposition (Name of cemetery,	S Stree	20c. Location - Ci	Balto, MD ty or Town, State		
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 K Burial 2 Cremation 3 Removal from State King Memorial Pk 4 Donation 5 Other Specify:	-2-2010	Randal	lstown, MD		
Baltimo permit. Page Department Important: injury or otl	Ì	21. Signature of Funeral Service Licensee 22. Name and Address of Facility					
E E E E		C. Mora		ue Balto	, MD 21218 Approximate Interval		
Physician W-dina		23a. Part I. En/er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.		rest, snock, or neart	Between Onset and Death		
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death) a. Methadone intoxication and cocaine Due to (or as a consequence of):	use				
		Sequentially list conditions, b					
	ine	if any, leading to immediate Due to (or as a consequence of):					
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	-				
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and nipletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	X UNPENDED AMENDED 23a,27,28a-f,permE, g902 4/12	/10 TT				
760, icate be physic the bur	Me	IF FEMALE: 23c, If yes, outcome of pregnancy		23d. Date of delivery			
687 certifi nding ise as t	sician	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pr 4 Pregnant at time of death 5 Other (Specify)	regnancy	Month	Day Year		
O. Box 687 at the death certific d by the attending p	ysic	1 Yes 2 No 9 V Unknown					
P.O. es that the igned by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			te to the cause of death? Probably 4 Unknown		
S, P.C uires that an signed ld be deta	ed b				re autopsy findings available		
ord aw req as bee	Completed		auto		r to completion of cause of		
tal Recolisan: The law certificate has	E		1 ✓ Yes		Yes 2 No		
Vital Pysician: his certiff director,	Be	25. Was case referred to medical 26. Place of Death (Chexaminer? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other N		Residence 6	Other Scene		
n of Vital Records, Ling Physician: The law requir After this certificate has been s funeral director, page 2 should t	<u>1</u>	1 V Yes 2 No 28a, Date of Injury 28b. Time of Injury 28c. Injury at Work?		how injury occurred	34101, 300110		
on on carding ath.	tion	1 Natural 5 Pending (Month, Day, Year) The Accident Prestination Fd 3/22/10 Fd 8:30 am 1 Yes 2 🗓 No.	o unk				
Division tal or Attendii rs after death.	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location or Town,	(Street and Number State) 2440 N	or Rural Route Number City		
Divisospital or A hours after meral Direct by filled in E	Cer	4 Homicide (Specify)	Baltimo	ore, MD			
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	red at the time, date	use(s) and manner as e and place, and due	to the cause(s)		
To witi	Me	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)		
		O.C.M.E.		March 23, 20	10		
	Ì	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore	MD 21201				
	ate	31, Date filed (Month, Day Near) 32, Registrar Signature	5, IVID 2 1201				
S Regis	tate trar	St. Date Hoof Month, Lay Age R 0 9 2010 Leneur S. barks					

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ April 1 7:50 P M 2010 Victor John Reed Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Baltimore Nottingham 9110 Bowline Road Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F 1 0 / 1 2 / 1 9 4 4 ort Benning, Director 215-42-8252 65 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Nottingham 1 Yes 2 X No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21236 USA 9110 Bowline Road or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married þ 1 Yes 2 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify than "natural", Specify: white 3 Divorced 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours popartment of health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Superintendent Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဂ္ Madonna Catherine Linsler Albert Monroe Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Fox Chapel Drive Timonium MD, 21093 Terri McShain/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/12/2010 Dulaney Valley Mem. Timonium, MD 21. Signature of Funeral Service Licensee Funeral Home, Inc. 1050 York Road Ruck Towson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cance stric Shysician/ disease or condition resulting in death) mou Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as it Reed, Victor T.O.D Division of Vital Records, P.O. Box 687 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy the Hospital or Attending Physician; The 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SOLARE DRIVE STE 2200, BALTIMORE, M.D 9103 UMAN 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend 29c & 30 per DVR g902 4/9/10 TT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1 - State Registrar		C	ertificate of		Wichter Fry	Reg. No.	2010	10974
Physic		Decedent's Name (First, Middle, Last QUEEN ESTHER R	*				2. Date of Dea Month March		Year	3. Time of Death
Med Exam		4a. Facility Name (if not institution, give			4b. City, Town, o	or Location of Deat			2010 County of Death	5:30 AM
1		Casey House			Rockvi				ntgomery	
Funera Directo		5. Social Security Number 6. S 577-48-5465 1		. last birthday 88 Yrs.	Months Days	If Under 24 Hrs Hours Min		th y, Ye <i>ar</i>) 20 10	9. Birth Cour	place (State or Foreign htry) h Carolina
aryland a-f show fied at		Usual Residence of Decedent 10a. State Maryland Prince Ge		City, Town or I	Location 1ville		тверс.	29.13		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
vith the Ma 23a or 28 st be noti	Funeral Director	10e. Street and Number 10808 River Oaks			10f. Zip Code 2072	1		10g. Citiz	en of What Cou	
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	ed by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates.	J.S. 13	3. Was Decedent of HIF Yes, specify Cub	an, Mexican, Puer	specify Yes or No- to Rican, etc.)	1	can Indian, etc.	
1215-(thin 72 hou sne. than "natu	Completed by	15. Decedent's El (Specify only highest gra Elementary/Seconday (0-12)		(Giv	edent's Usual Occup le kind of work done DO NOT use retired, mbly Line	during most of wo	rking		d of Business In	·
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam once.	To Be (12th 17. Father's Name (First, Middle, Last) Jep Steel		nose	mory diffe	18. Mother's Na	me (First, Middle, i Smith			prices
i, Mary nd 2 should ealth and N n 27 is ma		19a. Informant's Name/Relationship (7)			iling Address (Street 08 River					
0		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Place of Disp cemetery, cri binson	position (Name of ematory or other pla Cemetery	oe) 04-	Date 10-2010		ation - City or To	
Baltime permit. Page Department Important: I any injury o	di A	21. Signature of Funeral Service Licens	. Doun		4308 Suit	land Road	d Suitla	nd, M		, Inc.of Md 20746
Physician/ Medical		23a. Wart 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the define cause on each line. END STAGE Due to (or as a conse	HEART		ng, such as cardiad	or respiratory arre	est,		Approximate Interval Between Onset and Death
Examiner		Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a conse							
rificate be executed ing physician and as the burial-transit	cal Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a conse	quence of):						
8 / 60 tificate b ng physi as the t	Medical		d				· · · · · · · · · · · · · · · · · · ·			
BOX 6 death cer ne attendii ed for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of death 3 Ectopic pregnancy 23d. Date of death Month 2								ery Day Year
INISION OT VITAI RECORDS, P.O. or Attending Physician: The law requires that the after death. Director: After this certificate has been signed by the funeral director, page 2 should be detach in by the funeral director, page 2 should be detach.	by	Part II. Other significant conditions of RHEUMATOID ARTHR		sulting in the	underlying cause gi	ven in Part I.				ne cause of death?
VITAI KECONGS, ysician: The law requires is certificate has been sig director, page 2 should b	Completed						24a. Was a autops perfor		24b. Were autop prior to col death? 1 Yes	osy findings available mpletion of cause of
ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Che		2 🗆 1401	1 103	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	cate: To	1 ☐ Yes 2 🛣 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pending 2 ☐ Accident Investigation	1 Inpatient 2 Inpa	ER/Outpation 28b. Time of injury	of 28c. Injury	4	lome 5 Reside 28d. Describe ho			Hospice
DIVISION tal or Attendii rs after death. al Director: Al	l Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
the Hospin hin 24 hour the Funerampleted fill	Medical	only one) 3 Certifying Nurse	ician: To the best of my knowner: On the basis of examination Practioner: To the best of n	on and/or inve	stigation in my oninid	an death occurred	at the time date on	d place or	nd due to the cou	ica(a) and manner stated
P. With		29b. Signature and title of certifier J Kouatc	hou, mi		29c. License number D63748 29d.				Date signed (Month, Day, Year)	
2		30. Name and address of person who co Jocelyne T. Koua	tchou, MD 201	E. Un		Pkwy, Ba	ltimore,	MD 2	21218	
Sta Registr		31. Date filed (Month, Day, Year)	32. Registr r's Signa 2010 — Chase		Sare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month NEm max Medical 201 0 4a. Facility Name (if not institution, give street **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4000 7021 Omer 63 DAME 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 8. Date of Birth (Month, Day, Mar . 2 , Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Hours Min. 071-38-2615 Director 67 Mar. Usual Residence of Decedent 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 23a or 28a-f MD 1 Yes 2X No Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral must 16323 Boswell Pl. 20772 USA ıral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes, Give "natural" Specify: 3 Widowed 4 X Divorced Year or Dates Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 2yrs CNA Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I sem 27 is marked o marked ည Casper Rowland Marrie Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16323 Boswell Pl. George C. Rowland-Son Upper Marlboro, Md. 20772 item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State 0 = 10 cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Department of Important; If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Mt. Plesant Cemetery 4-10-2010 Signature of Funeral Service Licensee Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 18 months? 5 Other (specify) Pregnant at time of death Month Day Year 1 ☐ Yes 2 № 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed certificate 1 🗌 Yes 2 🗌 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After the Funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the function of the functio 28d. Describe how injury occurred 1 Natural
2 Accident injury work? 1 ☐ Yes 2 X No 5 Pending ell forward out of wheel chair 9:45 AM Investigation 1210 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Usper Nachboro Transportation 16. mo Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04 05 20°10 Dorothy Kookie Ross 6230P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Ritche House Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiec Country) MD **Funeral** Days Hours 1 M 2 DE 9/22/1957 Director 220-76-7747 52 Usual Residence of Deceden ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with ti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 1205 East Federal Street 21202 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by $X_3^1 \ \square \ \text{Never Married} \ \ 2 \ \square \ \text{Married} \\ X_3 \ \square \ \text{Widowed} \ \ 4 \ \square \ \text{Divorced}$ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ to Specify. Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Services Environmental Health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence Allen Dorthy Bell Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 East Federal Street Balto Md 21202 Krystal Traynham 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/12/ 10 | Balto MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Phillip A. Weatherford Fs PA 2431 E.Oliver St Balto Md 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. Carcialoresio disease or condition VRAC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atten I be detached for u in the past 12 months? Month Day Year 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires I within 24 hours after death.
To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown DO RO+# 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hespice Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at 28d. Describe how injury occurred 1 X Natural work 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Ijem 23a) (Type, Print)

Harold C Stand, bord Jo. Richer Hospice Bultmore MD Joseph 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 09 Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Barbara Riley Month Day Year Medical April 2010 10:20 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 169 Clamshell Rd. Ocean City Worcester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Pay, Year) Oct. 17, 1938 Days Hours 1 □ M 2**XX**F Maryland **Director** 212-36-3189 71 Usual Residence of Decedent show ral", or items 23a or 28a√f sho Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Maryland Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 169 Clamshell Road 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", 3 XWidowed 4 Divorced or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Md. Casualty Elementary/Seconday (0-12) College (1-4 or 5+) Filing Clerk Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည George William Harp Mary Virginia Bailey of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia L. Eberly Daughter 45 Hockersville Road Hershey, PA 17033 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Atlantic Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/9/2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Sign ture of Funeral Service Licer Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) UNG Cancer year Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year signed by the a ☐ Pregnam. ☐ Unknown 1 ☐ Yes ≥ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstructive pulmonary within 24 hours after death.

To the Funeral Director: After this certificate has been sit completed filled in by the funeral director, page 2 should I 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 A Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 🗷 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practices: The cost of my but will be contacted to the cause (s) and cost of the cause (s) and manner stated. (Check list the time, date and place, and due to the caucaje, and main at ac state 29c. License number April 5,2010 D0059945 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 7/2009

Registrar

Kristine Griffin Mo

31. Date filed (Month, Day, Year)

32. Re a trar's Signature

33195 Lighthouse Road, Suite 6, Selbyuille, DE 19975

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Francisca Suyapa Sorto DE Rosales Physician/ APRIL Day 2010 Year 4:05 Αм FRANCISCA SUYAPA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, Country) L Salvador Director 1958 /17/ unknown Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Hyattsville 1 XYes 2 No Maryland Prince George S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20784 3910 Meadow Trail Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. by 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Hispanic Specify: 3 🗆 Widowed 4 😾 Divorced Completed Hispanic permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical. Once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5 + Elementary/Seconday (0-12) Motor Vehicle Admin. Driving Instructor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gavina Guzman Domingo Sorto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3910 Meadow Trail Lane Hyattsville, Md 20784 Jose H. Rosales, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/7/2010 1 Durial 2 Cremation 3 Removal from State Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home, Inc. Signature of Funeral Service Licensee M00977 Marshal 4217 9th Street, N.W. Wash. D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Relapsed Auste disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No ģ Day 5 Other (specify) 1 ☐ Yes ∠ ⊭ 9 ☐ Unknown should be detached 9 I Inknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? this certificate 1 X Yes 2 □ No 1 ☐ Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 🗌 Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury To the rivestrater death.

To the Funeral Director: Aft 2 Accident 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the reuse. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) arochelle April 3, 2010 D0059581 MD

DHMH 17 Rev 7/2009

State Registrar egistrar's Signature

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDRE LAROCHELLE

31. Date filed (Month, Day, Year)

Amend #1 per MD g902 4/9/10 TT

For Amend #5, perFh G902 4/9/10 TT

Department of Health and Mental Hygiene State
Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Physician/ APRIL 2010 Dinah Rubin 6 PM 3:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1701 POMONA DRIVE, APT. #2 BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 2194ial 194urit3708er 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. /227 1923 **Director** 86 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 💢 No MD BALTIMORE BALTIMORE 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a P permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Medical Examiner must be once. Funeral 1701 POMONA DRIVE, APT. #2 21208 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify. Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES RETAIL SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ SAMUEL ZWAGIL SARAH MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, JEFFREY SCHUSTER/GRANDSON 3140 PYRAMID CIRCLE, MANCHESTER, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HAR SINAI CEMETERY 4/8/2010 OWINGS MILLS, MD e of Funeral Serve Lic 22. Name and Address of Facility SOL LEVINSON & BROS. N ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one ca on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it can, recome to infried atto-cause. Enter Underlying Examiner Due to (or sele-conecquence of, the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year 1 Yes 2 Unknown should be detached ☐ Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l page 2 s autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tile of cert 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) BULTO MD 21208 0 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month M Katherine Elizabeth Stamerro Medical *Z0/* 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Sal If Under 1 Year 8. Date of Birth (Month, Day, Year) June 10, 1928 If Under 24 Hrs. **Funeral** Age (In 9. Birthplace (State or Foreign 1 □ M 2 □XF Months Days Hours maryland **Director** Yrs 214-24-7705 Usual Residence of Deceden iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Md. Anne Arundel Severna Park 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 86 Point Somerset Lane 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, et "natural", or þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X filed within 72 hours after White 1 ☐ Yes 2 No Specify: 3

Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Granville Brown Agnes Hanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allyson Grames 86 Point Somerset Lane Severna park, Md. 21146 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Highview Memorial 4-10-2010 Fallston, Md. 21. Signature of Funeral Service Licensee Schimunek Funeral Home 22. Name and Address of Facility Bal 9705 Belair Rd. Nottingham, md.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Dire to for as a consequence of the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical v requires that the death certificate be been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death detached Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cayse given in Part I. 23e. Did tobacco use contribute to the cause of death? should be ronari 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an the Hospital or Attending Physician, the law hin 24 hours after death.

the Funeral Director: After this certificate has page 2 autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at s after death.

I Director: After to in by the funeral 28h Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person completed cause of death (Item 23a) (Type, Print) State Registrar

amend item 8 per fth Department of Health and Mental Hygiene 1- State of Maryland Department of Health and Mental Hygiene Registrar

1- For Amend 28a, per MD g902 4/19/10 TT Certificate of Death

Reg. No. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Physician 8:19 PM Hans Steer DR 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEALTheare BALTIMOI N/A AGNES SAINT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 XM 2□ F Months Jan. 14, 1954 Director 154-48-6524 56 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "horizal Examinar", ust be notified at 1 ⊈Yes 2 ☐ No Director N/ABaltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 U.S.A. 2314 Falls Gable Lane, Apt. E Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 if Yes, Give Year or Dates: 1 ☐Yes 2 🛛 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Environmental Elementary/Secondary (0-12) College (1-4or 5+) Director of Sale Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be flealth and Mental Steer Usulie Erwin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 is 1842 Winsloe Drive Trinity, Florida 34655 Brother Steer Robert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson Maryland Hilltop Service Corp. 4-12-2010 21. Signature of Pur rai Service (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NEUMONIA **Physician** SPIRATTON 2 HOUR disease or condition resulting in death) /Medical Due to (or as a consequence of): ENTON PROTO PLACE Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to for as a conseque in- off burial-transit Exami Due to (or as a consequence of) ing physician as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical the attending IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy signed by the atte Month 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown INJUR Completed after death.

I Director: After this certificate has been in the second of the second 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day 28a 2009 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural NOVEMBER -T FALL UNK 1 ☐ Yes 2 ☑ No 2 Accident 28e. Place of Injury - At hom building, etc.) Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) At home, farm, street, factory, office determined 4 Homicide Kins e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number APRIL 7, 2010 DO051865 900 CATON AVE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57 MARLES CURTIS AGNES BALTIMORZ, MD 21229 HUSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year David Lawrence Schultz 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ale HOSpita 05 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Days Hours Min Director 216-52-3955 61 June 11, 1948 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 22a or 28a-f show any injury or other traumatic event, the Medical Examination ust be multipled at Director 1 ☐ Yes 2 X No Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8901 Talc Drive, apt. Cl Funeral 21237 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No þ Specify Specify: 3 Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 12 <u>Security Officer</u> School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Leopold Francis Schu1tz Margaret Devlin Mamie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris C. Haga/Sister 18667 Middletown Road, Parkton, Maryland 21120 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4/9/10 Glen Burnie, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 bryan 23a. Part 1. En'r t e disease, or complications that o shock, o head failure. List only ne cause on e aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Couse Final disease or condition Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 No detached 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an 1 ☐Yes 1 ☐ Yes 2 ☐ No 2 No After this certification funeral director, g 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No the 1 within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier

X

State Registrar Dul

30. Name and address of

Date filed (Month Day,

MY

ause of death (Item 23a) (Type, Print)

D0063974

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day DA -36 Medical pm' 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 100 COUN **Funeral** 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔽 F Months Days Hours Min. (Month, Day, Director 29-40-4856 <u>May</u> Usual Residence of Decedent shov 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 28a-f must be notified 1 X Yes 2 No MD Baltimore ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a Fulton Ave. 1615 N. 21217 USA ral", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ Black, White, etc 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: Specify: Black "natural" Completed 3 🗌 Widowed 4 🔀 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u>Homemaker</u> Residence other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of မ Mattie Fleet <u>Ernest Smith</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Nicole Brunson-daughter N. Hilton Street Baltimore, MD 21217 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. 4/10/2010 Baltimore, MD 11. Signa ure Funeral Service License 22. Name and Address of Facility 4300 Wabash Avenue Baltimore, MD 21215 FH West March and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between nediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) e to (or as a consequence of): Examiner 166 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of burial-transit mo and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year ned by the a detached t 9 Unknown 9 Unknown P.0. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe page Yes 2 1 No 2 🗌 No 1 Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes ည 2 📈 No I ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 🖈 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) After the funeral Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending neral Director: A death. 1 🗌 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

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Registrar
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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2 Date of Death 4 Month **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–16–1955 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** 217-66-5255 54 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Examiner must be notified at Yes 2 No Director MD na Baltimore 10g. Citizen of What Country? 10f Zip-Code 10e. Street and Number items 23a or 21213 U S Α 3310 Lyndale Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X X**No 0 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black Specify: 2 3 ☐ Widowed 4X Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene.

Is marked other than Cashier B. C. C. C. 10th grade 18. Mother's Name (First, Middle, Maiden Surname) or other traumatic event, 17. Father's Name (First, Middle, Last) Be James Tonkins, Sr Mary Marks ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other tra Tiera Cunningham-daughter 3310 Lyndale Avenue Balto, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk 4-10-2010 4 Donation 5 Qther (Specify) Randallstown, MD 21. Signature of Funer Service Licens. 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fulure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Enter the ul monary Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequent of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Live birth 2 Fetal death Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medica Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be determined 4 - Homicide within 24 hours a

To the Funeral D Hospital 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HSU Steven 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 9 2010

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32. Registrar's Signature

Please Type or Print in Black indelible Ink. Epsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:30 AM April 4, ^{Year}01 Catherine Elizabeth Thomason Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Brighton Gardens Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace State or Foreign **Funeral** ^{Year)}191<u>3</u> 1 M 2 F 97 Days Hours Min Jan 13 318-36-4783 Yrs. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director Towson 1 Yes 2 No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö Funeral items 23a 21204 United States 315 Southwind Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify. "natural", Completed 3 ₩idowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Public/Private Teacher Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel James Dennis Walker ě f and 2 should the Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra. Joan Harrison / Daughter 315 Southwind Road Towson, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Apr 06 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives MOTHY 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown should has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed page death? certificate 1 ☐ Yes 2 ☐ No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ASIISTEDINI 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗆 No 1 Yes Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Year 2010 12:40 PM Betty Taylor 7, April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunbridge Care for Elkton Elkton Cecil 8. Date of Birth (Month, Day, Year May 23, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□ M 2 F 81 Months Days Hours Min Year) 215-24-0910 Director 1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Modieal Evantment for a ruffled at once. Director 1 ☐ Yes 2 No Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 334 Post Rd 21001 Funeral 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, GiveYear or Dates: 1 Never Married 2 Married 1 □Yes 2 No þ Specify: Specify. 3 Widowed 4 □ Divorced White Be Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Hospitality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver Frank DuFour Ruth I. Bell ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Wagner /Daughter 334 Post Rd. Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Apr 09 Beltsville, Maryland Chesapeake Crematory 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Li 8717 Green Pastures Drive Towson Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nonsequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 XYes 2 □ No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

To the Hospital or Attending Physician: The law requires that the death certificate be executed y physician and strans Division of Vital Records, P.O. Box 68760, attending p certificate has been signed by the rector, page 2 should be detached funeral director, After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

SHAHNAWAZ 31. Date filed (Month, Day, Year) State Registrar

MD

29c. License number

29d. Date signed (Month, Day, Year)

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2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

III W. HIGH STREET

SUITE 314

ELKTON MD 21921

29b. Signature and title of certifie



10-02621 Rhonda Thomas

Please Type or State of	Print in Black Indelible Ink. Ensure All (Maryland / Department of Health and Mer	Copies Are Legible. 2 0	10	10	98
State	Certificate of Death				
ar	- Corumatio or Boutin	Reg. No.			

Tallottaa Tilottiaa		1- For State Registrar	Cer	tificate of De		i wentai m		j. No.	1000
Physicia	ın/	1. Decedent's Name (First, Middle,La					2. Date of Death		3. Time of Death
Medical Exami	ner	Khunda 4a. Facility Name (if not institution, gi	I homas	l 4h Ci	ty Town or I	.ocation of Death	April 3, 201	0 4c. County of Deat	1837 hrs
<i>*</i>		114 Willard Street	e street and number)		Itimore	.ocalion of Death		N L	A
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. la		Inder 1 Year	+	⊣	(MM/DD/YYYY) 9. Bir	
Director		011 10 0140	M 2 F	40 Yrs. M	onths Days	Hours Min.	Feb 18		untry) Maryland
yna	}	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
nd show s	٦	MD NI	A	Balt	TM	ore			1 1 Yes 2 No
Maryla 28a-f	Director	10e, Street and Number	4 4	10f.	Zip Code		109	g. Citizen of What Cou	ntry?
th the 23a or		114 S. W	illard.	St 6	2120			USF	7
eath wi	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?			panic Origin? (Sp Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
after de	by Fu	3 Widowed 4 Divorce	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes	2 No	specify:		Specify: B	lack
hours.		15. Decedent's Education (Specify of	nly highest grade completed)	16a. Decedent's Us during most of		on (Give kind of w DO NOT use retir		16b. Kind of Business/	Industry
36 hin 72 e. than	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Social	+12	Gua	nd l	MT	A
5-00 led wit Hygien other		17 Father's Name (First, Middle, Last		e e cuo	1	8.Mother's Name	(First, Middle, Ma	aiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than ic event, the Medica	8		ung	T		Kub	y Co	rbett	
MD 2 td 2 shoul ulth and M m 27 is m aumatic	٤	19a Inform t's Na Relationship (- mother.	LHA52	ess (Street	1 1 1	al Route Numb	er, City or Town, State	, Zip Code) MD 21229
	ı	20a. Method of Disposition	20b. P	Place of Disposition (rematory or other pla	Name of cem	0 -0 .		20c. Location - City or	Town, State
Pages nent of ant: It		1 Burial 2 Cremation 3 4 Donation 5 Other Specify	Tremoval from State	etro Cr	emat	ory 4	8/2010	Balti	More, MO
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr	-	21. Si octure of Funeral Sara é Lice	see	22. Name a	and Address	1 170	well	Flygra	2 Home
Physician	1	23a. Part I. Enter the disease, or comp	olications that caused the death.	Do not enter the mo	de of dying, s	Such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval
Examiner		failure. List only one cause on e Immediate Cause (Final disease a.	schline. Seizures						Between Onset and Death
Examilier		or condition resulting in death)	Due to (or as a consequence of):					
	١	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):					
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876(tificate ng phy as the b		IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome of pregn	ancy 2 Fetal dea	ath 3	Ectopic pregnar	ncy	23d. Date of delivery Month	y Day Year
ox 6 ath cerratendii	Physician/	past 12 months? 1 Yes 2 No 9 ✓ Unknown	4 Pregnant at time of dea						
by the		Part II. Other significant conditions	a Olikiowii	sulting in the underly	ring cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 687 tal or attending Physician: The law requires that the death certific its after death. **I Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	ρ						1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
v requi	Completed						24a. Was an autopsy		topsy findings available ompletion of cause of
Recc The lav	ĕ						perform 1 Yes 2	ed? death?	s 2 No
cian:	B B	25. Was case referred to medical examiner?	lospital: 1 losstiant 2			of Death (Check of Death (Chec		,	
of Vi	유	1 Yes 2 No 27. Manner of Death	i inpatient 2	ER/Outpatient 3	DOA 28c. Injury			esidence 6 🗸 Other winjury occurred 1n	
OD C ending ath. or: Af	틽	1 Naturai 5 Pending	(Month, Day,Year)	unk				hicle coll	
or Att	Certification:	2 X Accident Investigat 3 Suicide 6 Could not	be 28e. Place of Injury - At ho		ory, office bui	ilding, etc.	28f. Location (Str or Town, Sta		ral Route Number, City
ospital hours a		4 Homicide 29a. Certifier A Certifying Physic	roadway				New Jers	ey	
Division of Vital Records, P.O. Box 68760, To the Hospital or Artending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burfal - transit	Medical	(Check only	an: To the best of my knowledgOn the basis of examination an						
ţ. iž ţ. i	š	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed (Mor	nth, Day, Year)
		aness			O.C.M	l.E.		April 4, 2010	
		30. Name and address of person who Ana Rubio MD. Assista	· ·	^{23a)} 11 Penn Street	Raltimor	e MD 21201			
Str	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	е.		G, IVID Z 1ZU I			
Regist		APR 0 9 2	110 Deneus	A. Jack	4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month & Year **Physician** Richard Hudgins Williams 2010 10:40 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto Towson Manor Care Ruxton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 1 XM 2 ☐ F Months Days Hours Min. 71 <u> 216-34-1786</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ty Yes 2 □ No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 521 Oakland Avenue 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes ANO Specify: \$ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Home improvement na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Williams Thelma Hudgins ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Williams -Wife Oakland Avenue Balto, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 4 Donation 5 Other (Specify 3 Removal from State 4-9-2010 Dulaney Valley Timonium, MD March East F/H 21. Signature of Fuser Service 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) brovas week Due to (or as a consequence of): Sequentially list conditions, if any, leading to infine distribute. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23h Was decedent pregnant Be Certification: To

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur

Funeral

Director

ms 23a or 28a-f sho

Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hyglene.

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permit. Pages 1 Department of H Important: If ite any Injury or ot

Physician

/Medicai

Examiner

attending physician and for use as the burial-trar

been signed by the should be detached

After this certificate has funeral director, page 2:

Baltimore, Maryland 21215-0036

in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		nancy fy)		Month Day Year			
Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause	e given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
				24a. Was an autopsy performed?				
25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
1 Yes 2 YNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA	Other: 4 Nursing H	ome 5 Residence	6 □ Other (Specify)			
27. Manner of Death 1 A Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Ďay, Year) on		Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in				
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		farm, street, factory, off	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 Certifying F (Check only 2 Medical Exa	hysician: To the best of my knowled uminer: On the basis of examination a	ge, death occurred at the	he time, date and place my opinion, death occu	, and due to the cause	e(s) and manner as stated.			

29c. License number

29d. Date signed (Month, Day, Year)

State Registra

Medical

29b. Signature and title of certifier

Date filed (Month, Day, Year, APR 0 9 201

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5, 20a per fh g902 4-9-10 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:55 P M James Warren Wellman April 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death HOSPITCH OF BOUTINOIS Baltimore City 5. Social Security Number 9659 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 17, **Funeral** 9. Birthplace (State or Foreign Days Hours Min. 70 **Director** 213-38 Maryland 1939 I W SUMMED WILLEUMMONT Maryland 21215-0036 Usual Residence of Decedent show 10a. State at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f slany injury or other traumatic event, the Medical Examiner must be notified. 1. Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Completed by Funeral** 4601 Pall Mall Road 21215 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1X Never Married 2 ☐ Married If Yes, Give 1 Yes 2 No Specify: 3 Divorced Specify: Korea White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Moving and Storage Mover Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph Warren Wellman Catherine German 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), William R. Levasseur 22 W. Pennsylvania Avenue Ste. 202 Towson Baltimore, 20a. Method of Disposition
1

■ Burial

■ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney Valley 08 Timonium, 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licensee 22. Nance em Made to M Failled Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ disease or condition resulting in death) Pheumbnia Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 4 ☐ Pregnant g ☐ Unknown Yes 2 No been signed by the should be detached 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown mellitus 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy Schi zophrenia paranoid performed? Yes 2 No 2 🖳 No Yes 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work?
1 Yes 2 No ☐ Accider☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address of person who comp anci Hospital duffredini 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Melvin Wines, Jr.	لــــــــــــــــــــــــــــــــــــــ	1- For State Registrar	te of Maryla	and / D		ment of ficate of		d Menta	l Hygi		eg. No.	20	10	1099
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Francis	4	Calvert Memorial Hospi 5. Social Security Number 6	ital 5. Sex	7. Age (In	vre loet	hidhdou)	Prince Fred		ALIE TO	Data of Rig		alvert	O Diale	place (State or
Funeral Director			1 X M 2 F	7. Age (III	ryrs, iasi	Yrs.	Months Days					IF	oreign	otace (State or stry) DC
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the Mz a or 22 ciffed	Director	105 Holly Circl	le				20657	7				USA		•
5-0036 Journal of the Maryland store that with the Maryland lygene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.		11. Marital Status 1 Never Married 2 X Marr	12. Was Dec		r in U.S.		Decedent of Hises, specify Cuban				- 1	14. Race - A White, e		n Indian, Black,
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36 in 72 h han "n lical E.		Elementary/Secondary (0-12) 12th	College (1	-4 or 5+)			est of working life.	DO NOT us	e retired)		C	iant		
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exam	<u></u>	17. Father's Name (First, Middle, La	ast)			Dairy		18.Mother's N	lame (Firs	st, Middle, M				
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	å	Melvin G. Wines			Adeline Prince									
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Baltimore, permit. Pages I and Department of Heal Important: If iter injury or other tra	ш	1 X Burial 2 Cremation 4 Donation 5 Other Spec				natory or oth	n Nation	al 4	-6-2	010	Sui	tland	ı, M	d.
3alti ermit. Separtm mports njury o	Ī	21. Signature of Funeral Service Lie	censee	260	1		ame and Address							
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n of Vital Records, P.O. Box 6876i ding Phystcian: The law requires that the death certificate h. After this certificate has been signed by the attending phy finneral director, page 2 should be detached for use as the ton. To Be Completed by Physician/M.	2	F FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, o		pregnanc	-	al death 3	Ectopic pro	egnancy			Date of del fonth	livery Day	Year
box 6876 the death certificate by the attending phy ched for use as the Physician/M		1 Yes 2 No 9 Unkno	7	ant at time	of death	5 Oth	er (Specify)							
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Division spital or Atten hours after death neral Director: y filled in by the Certificati		3 Suicide 6 Could n	lot be	of Injury -	At home,	farm, street	factory, office bu	ilding, etc.		ocation (Stor Town, Sta		Number o	r Rural	Route Number, City
C The Bar		4 Homicide	sician: To the best	of my kno	wledge, o	leath occurre	ed at the time, dat	e and place.	and due to	o the cause	e(s) and r	manner as	stated	
Div To the Hospital or within 24 hours after To the Funeral Dir completely filled in completely filled in ledical Certif		one) 2 Medical Examin		f examinat										ause(s)
A TATO		9b. Signature and title of certifier					29c. License					ate signed		Day, Year)
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\forall	13	 Name and address of person wh Donna M. Vincenti, MD 	Assistant M				Penn Street,	Baltimore	MD 21	201				
State Registra	e 3	APR 0 9 2010	32. Reg	gistrar's Sig		back	,							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010^{ear} APRIL LILLIAN L. WITTEN 3:00 A.M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 2525 POT SPRINGS ROAD APT. S226 TIMONIUM BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Months Days Hours 1 □ M 2 X F 218-22-0884 86 2/26/1924 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County BALTIMORE TIMONIUM 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2525 POT SPRINGS RD. APT. S226 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) YEARS HOMEMAKER OWN_HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDWARD HAMMANN MARY ELIZABETH MOOYER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRYAN VOSS/SON 816 STAGES HEAD RD. TOWSON. MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 4/6/2010 CATONSVILLE. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MCC217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show

?? is marked other than "natural", or items traumatic event, the Medical Examiner ms

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite ary or other traumatic event, I'm Mudical Evanina

permit. Page Department o Important: If any Injury or

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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MD

the Maryland

death with

and burial-tra

P.O. Box 68760,

Division of Vital Records,

Examine Physician/Medical Be Completed by

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Certification:

Medical

29b. Signature and title of certifier

Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician page 2 should be detached for use as the buria this certificate To the Hospital ... within 24 hours after death.

To the Funeral Director: After this c

9 ∐ Unknown		3 3										
Part II. Other signif	icant conditions o	contributing to death but not res	ulting in the underlyin	g cause given ir	Part I.	23e. Did tobacco us	se contribute to the cause of death? No 3 Probably 4 Unknow					
Hyper	gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc 1	autopsy performed?										
25. Was case refer	red to medical		26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 🔯	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	lome 5 Residence 6	me 5 Residence 6 □ Other (Specify)							
27. Manner of Death 1 → Natural 2 → Accident	5 Pending investigation	(<i>Month, Day, Year)</i> n	Injury	Work?	2 □No	28d. Describe how injury	occurred					
3 ☐ Suicide 4 ☐ Homicide		28e. Place of injury - At no	ome, farm, street, fact fy)	28f. Location (Street and City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only	1 Certifying Ph	hysician: To the best of my kno miner: On the basis of examina	owledge, death occurration and/or investigat	red at the time,	date and plac	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)					

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Jeneus

ERNESTINE WRIGHT 2300 Dulaney Valley Rd., Timonium, MD 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 20b, c per fh 2902 4-13-10 yt
State of Maryland Department of Health and Mental Hygiene [] | []

1- State Amend #1, per MD G902 4/14/10 Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Alphonzo. Wilson **Physician** /Medical Facility Name (If not institution) give street and number) ſŪ 4b. City, Town, or Location of Death Examiner 4c. County of Death Keha 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Min. Days 1 X M 2 □ F Months Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be mostlished as once. Director 1 Yes 2 □ No Timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 223 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 NYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Blac 16b. Kind of Business/Industry þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ liams 19a. Informant's Name/Relationship (Type. Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 4-15-10. f Funeral Service License 22. Name and Address of Facility L. Russ Funeral Home P 23a. Part 1 Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner the burial-transit NA or Attending Physician; The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Yes 25 1 □ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation s after death. 1 TYes 2 No filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Datę signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Conjus Koven 31. Date filed (Month, Day, Year) APR 0 9 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#28a, perME, G907, 9/28/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March Physician/ 24 Pay 2010 Lucillë: Virginia 6:55 P Washkevich Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 27 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) 1 🗆 M 2 🖵 F Months 215-34-7133 92 **Director** Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No MD Cockeysville Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral 1012 Bosley Rd. 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: white Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pattern Cutter Clothing other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher ပ Bertha Viola Naylor Howard William McCoy permit. Page 1 and 2 should be Department of Heaith and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald N. McCulloh/son 10562 Gateridge Rd., Cockeysville, MD 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Atlantic Crematory 3/26/10 Glen Burnie, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Rd., Timonium, MD 2109 Inc. MUCHAN Part 1. Enter the disease, or complic shock, or heart failure. List only one aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ich line. Approximate Interval Between Onset and Death ions that Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and I-transit Exami Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death Unknown 1 Yes 2 9 Unknown ed by the a detached i Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed this certificate Yes 1 ☐ Yes 2 ☐ No 2 X No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 N Other (Specify) 1X Yes 2 ☐ No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month) Pay, Year) MARCH 22, 290 27. Manner of Death 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: □ Natural 5 Pendina FALL 2 Accident No No UNHNOWN M 1 Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1012 803144 RDAO 4 Homicide determined COCKEYSVILLE, MD 2/030 AT HIME Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D64395 MARCH, 25, 2010 6701 N CHAPLES ST, SUITE 4105 BALTIMOREINS 21204 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MO 31. Date filed (Month, Day, Year) 32. Reg strar's Signature State Serena. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04 20[0 Wald Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Medica Baltimore Funeral If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country Maryland 1**XX**M 2 □ F 60 Months Hours (Month, Day, Year) 220-54-5664 Director 1950 Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MDBaltimore Nottingham 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7720 Bennerton Drive 21236 United States Was Deced Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black White etc. ģ 1XX Never Married 2 Married Maryland 21215-0036 1 Yes 2XXNo Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) 12 1 Public Works Environmental Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be in Department of Health and Ments Important: If item 27 is marked Philip Gordon Waldner Iolita M. Iarsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brittany Waldher - Daughter OR 97211 4536 N.E. 41st Avenue, Portland, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Crapel & Cremation Services - BelAir Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State injury or April 10,2010 Forest Hill, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Parkville 8800 Harford Road, Parkville, Maryland 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Stone End Liver Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant a
9 Unknown Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown 2 🗌 No the been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed Director: After this certificate d in by the funeral director, pag 1 Yes 2 16 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 🔲 Yes Other: ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 atural 5 Pending injury Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completed filled in by 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signat e and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lashyap Baltimore W Redwood MD 401 MD 21201

State Registrar 31. Date filed (Month, Day Year)
APR 0 9 2010

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			. For	State of Marylan				•	•	oie.	10005
_			1 - State Registrar		Cei	rtificate of	Death	R	eg. No.	U	10990
п	Physici	an	Decedent's Name (First, Middle, La	•				2. Date of Deat Month		Year	3. Time of Death
-	/Medi		Lena Mae Wall					Month –	14-201		3:51A.M
	Examir	ner	4a. Facility Name (If not institution, giv				r Location of Death		4c. County		
			Prince Georges 5. Social Security Number 6. S		la st hirthday)	Chever		8. Date of Birth			eorges
	Funeral Director		225-62-4294	□ M 2 🟋 61	Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Vir	place (State or Foreign htry) ginia
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	IOd. Inside City Limits
	death with the Maryland ma 23a or 28a-f show trnust be notified #1	to	MD Prince	Georges U	pper	Marlbor	0				1 ☐ Yes 2 X No
	or 28g	Completed by Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Cour	ntry?
	23a c	aiD	10133 Campus Wa	ay South		2	0774		USA		
	r dea	Iner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-		e - Americ k, White,	can Indian, etc.
36	s afte	Y FL	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 📉 No	Specify:			bla	
9	hour	pa pa	15. Decedent's E	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of Bu		
15	n "ne	piet	(Specify only highest gra	ide completed)	(Give	kind of work done of DO NOT use retired	during most of workir d)	ng			
21215-0036	d with	E	Elementary/Secondary (0-12)	College (1-4or 5+) 4 yrs.	соруз	right sp	pecialis	t ľ	urbrar	y οτ	Congress
Б	e file al Hy othe vant,	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Sumam	θ)	
Maryland	Menta Menta arked	2	Johnny Walltowe	er			Jessie .	Johnson	n		
a	2 sho and ts m		19a. Informant's Name/Relationship (• • • • • • • • • • • • • • • • • • • •	19b. Mailir	ng Address (Street	and Number or Rura	Route Number	City or Town,	State, Zip	Code)
2	and lealth m 27 her tr		Ulysses Walltow				ive, Ft.				
Ore	f of H		20a. Method of Disposition 1 Spurial 2 Cremation 3	Removal from State	lace of Dispo emetery, crer *XXXX	sition (Name of matory or other place Memorial	03/2	. /	20c. Location -	-	
Baltimore,	t. Pa rtmen rtant;		* 4 ☐Donation 5 ☐ Other (Specil	y/				±/10 g			'irginia
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itama 23e or 28a-f show any injury or other traumatic event, The Medical Examinat must be notified at Once.		21. Signature of Funeral Service Licer	tenu mon	-51	2. Name and Addre	Opening Street Service	Charal			reet NE
			שכ_	Approximate							
	Dhysisian		23a. Part1. And the disease, or comshock, or heart failure. List only Immediate Cause (Final	Fatal Card				,,	,		Interval Between Onset and Death
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	Examiner			Respirator		ilure					
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760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):						
6876	cate b	dical		d							
9 x	The law requires that the death certifica lie has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	nov						
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal	death 3	Ectopic pregnancy Other (specify)	,		23d. Dat Mor	e of delive nth	ery Day Year
o.	y the	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9 Unknown	3L	Other (specify)					
٥	es that igned b be deta	by PF	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contr	ibute to th	ne cause of death?
rds	n sign	q pa						1 □ Ye	s 2 🗆 No	3 🗌 Prob	pably 4 X Unknown
Records,	s been s	Completed						24a. Was ar	n 24b. V	Vere auto	psy findings available
Re	The law cate has I page 2 s	E O						autops perforn 1 Yes 2	ned?	rior to cor leath?	mpletion of cause of
		0	25. Was case referred to medical				26. Place of Death			1.63	20140
of V	S 5	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 💢	ER/Outpatien	t 3 DOA Othe				er (Specify	y)
			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	y at 2 k?	8d. Describe ho	w injury occurr	ed	
sio	ttendi death. ctor: A / the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No				
Division	after deati	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	2	8f. Location (Sti City or Town	reet and Number, State)	er or Rura	al Route Number,
	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune		29a. Certifier 1♥ Certifying Ph	voicion. To the head of an American							li
		edicai		ysician: To the best of my knowniner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my of	ne, date and place, a pinion, death occurre	d at the time, da	iuse(s) and ma ate and place, a	ind due to	the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of sertifier	2 1		29c. License		29	9d. Date signed	(Month,	Day, Year)
			1 M/	r I DA	~	D0063	688		4/3	10	
			30. Name and address of person who						1 1		
	V		Griffin L. Day	is MD 3001 H	ospit	al Driv	e Cheve	rly, M	D 2078	35	
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Signat	D. A	arke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician April EARL Н. WATSON (13^a) 20110 6:00 рм JR. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Road Anne Arundel Hampton Annapolis 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 24, 194 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 € M 2 □ F Months Days Hours Min 212-42-0687 67 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Martical Evantinat must be notified at once. 10b. County 10a State 10c City Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ▼ No Anne Arundel Annapolis MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1193 Hampton Road 21409 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 No
If Yes, Give 1 964-70
Year or Dates 1 964-70 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) glass production supervisor Ò 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl H. Watson Thelma I. Pitt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1193 Hampton Rd. Annapolis MD 21409 Patricia Watson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 4/8/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. LONACO <u>3204 Mountain Road Pasadena, Maryland 21122</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one author on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** bele las /Medical e to (or as a consequence of) **Examiner** Sequentially list conditions, ii ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar to (or as consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death signed by the a 5 Other (specify) 1 ☐ Yes 9 Unknov Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should I 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 □Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death? this certificate has ral director, page 2 s 1 ☐ Yes 2 No vurs after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1∐ Yes Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 □Yes 2 □ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Ph iclan To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) d manner stated. To the 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 29c. License number eted cause of death (Item 23a) (Type, Print) 30. Name and address of pers

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TSHMFAT, F. WILLARD April 2010^{ear} Medical 1:45 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7461 East Furnace Branch Road Apt. 9 Glen Burnie Anne Arundel 6. Sex 1 ፟፟ M 2 ☐ F 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Y March 3 Months Days Hours Director 220-24-3596 North <u>Carolina</u> 89 1921 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Marvland Anne Arundel 1 Tes 2 X No Glen Burnie 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 7461 East Furnace Branch Rd. Apt D 21060 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No 1 Never Married 2 Married Black, White, etc. þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates. "natural", 3 ☐ Widowed 4 ☐ Divorced Completed Specify White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Unknown Unknown <u>Machinist</u> Domino Sugar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerard J. Myers (Son-In-Law) 1417 Pennington Lane South Annapolis, Maryland 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 04/09/10 Glen Burnie, Maryland Signature of Funeral Service Licenses 32. Name and Acdress of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Pg. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, daily, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to (as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death
9 Unknown 5 Other (specify) Month Dav Yes 2 No 1 ☐ Yes 2 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate h performed Yes 2 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 IER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Vatural 5 Pending injury work? Accident
Suicide Investigation 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral D completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year,

APR

DHMH 17 Rev 7/2009

distrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2010 WILLIFORD March 7:27 a M MARSHALL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BOWIE HEALTH CENTER BOWIE PRINCE GEORGES Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 1 X M 2 □ F Months Hours Min. Yrs Oct. Director 577-46-7610 74 10, 1935 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2X No Directo MD Prince Georges Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code and 2 should be filed within 72 hours after death with lealth and Mental Hygiene. ö 20772 USA 14106 Spring Branch Dr. items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2X Married 0, 1 ☐ Yes 2X No Specify. Specify: Black by 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver S Freedman & Son's 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Williford Francis Hallums 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pages 1 and 2 street of Health a rtant: If Item 27 is Upper Marlbor, MD. 20772 14106 Spring Branch Dr. Esther Williford - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If Its any Injury or o 1 X Burial 2 ☐ Cremation 3 Removal from State Harmony Memorial Park 4-9-2010 Landover, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home of Maryland ictarine 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction immediate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ischemic Cardiomyopathy years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Coronary Artery Disease that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) the ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 □ Yes 2**X** No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 🔀 No 2X ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death.

Director: /
d in by the fi death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c License number signed (Month, Day, Year) 29b. Signature nd title of certifier 30. Name and address of person who comple cause of death (Item 23a) (Type, Print) Terence Bertele, MD 12070 Old Line Center Waldorf, MD 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State APR 0 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Hnna 4505AM Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville Charlestown Care Center 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Days Months Hours Min. Director 215-12-0255 87 Maryland Sept. Usual Residence of Decedent 3a or 28a-f show t be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No Baltimore Maryland Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral event, the Medical Examiner must 707 Maiden Choice Lane Apt 8210 21228 USA "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ò 1 Never Married 2 Married 21215-0036 1 Tes 2 No Specify If Yes, Give Specify: White 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Joseph Denis Nellie Rebecca Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Zimbro Daughter 1011 Green Acre Road; Towson, MD 21286 Department of Health Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4-9-2010 Glen Burnie, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service Licens 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Filysician/ disease or condition resulting in death) cerebra Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this continuate has been accounted. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fibrillation Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available Congestive 24a. Was an autopsy prior to completion of cause of death? 2 No 2 No 1 Yes 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my activity 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number mn 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2122.8

DHMH 17 Rev 7/2009

Registrar

Daneen

31. Date filed (Month, Day, Year)

Bou

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #20b, per Fh & 26, per MD 9902 4/9/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL **Physician** ZIDE 6 2010 9:29 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER CARROLL CARROLL HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, Year) 7/23/1922 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F GERMANY 155-30-9869 87 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be notified at 1 □Yes 2XINo Director CARROLL MD WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or: ury or other traumatic event, the Medical Examinational bain. 746 YOUNG WAY 21158 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 📈 No If Yes, Give Year or Dates: WHITE Specify Specify: 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **SEAMSTRESS** TEXTILES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STERN SAMUEL THEKLA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHEILA MAZUR/DAUGHTER 746 YOUNG WAY, WESTMINSTER, MD 20b. Place of Disposition (Name of cemetary cremitary or other place)
NEW MONTH-TORE CEM. 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4/8/2010 FARMINGDALE, NY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Doense 22. Name and Address of Facility 2. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Þ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Whocongio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for se's consequence of The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2☐No sate has been signed by the page 2 should be detached g 🗆 Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonon willodon 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy performed? 1 □ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home -5 Residence 6 Other (Specify) Hospital To the Hospital or Attending Physiwithin 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral dir Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA e Hospital or Attending Phys 124 hours after death. e Funeral Director: After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) answira, mo 04-07-2010 30. Name and address of person who completed cause of death (Item #3a) (Type, Print)

M. PANSURIYA 349 Mod Column

State Registrar

31. Date filed (Month, Day, Year) APR 09

Westminstor, MD 21157

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